Exploring the Relationship Between Job Satisfaction, Bullying, and Authentic Leadership Among Medical-Surgical Nurses

by

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Dedication

I dedicate this document to my parents, Cheryl and Brian Bennett, who taught me the value of hard work and who gave me strength and courage to chase after my dreams.

ABSTRACT

Background: Research suggests that medical/surgical nurses have lower job satisfaction than nurses in other areas. Research also reports that 80% of nurses will experience bullying in their careers and that leadership style has a significant impact on the organizational work environment. Authentic leadership is a relatively new concept, which has been linked to increased job satisfaction and decreased bullying. Although job satisfaction has been widely explored, the relationship between job satisfaction, bullying, and authentic leadership in medical-surgical nurses has not been studied. Therefore, purpose of this thesis study was to use the Organizational Framework for Predicting Nurse Retention to explore the relationship between workplace bullying, job satisfaction, and authentic leadership among medical-surgical nurses. **Methods**: As part of a larger study, a cross-sectional survey was utilized (N=317). Invitations to participate were sent to all medical-surgical nurses in Manitoba, via the College of Registered Nurses of Manitoba. **Results:** The findings revealed that an alarming 43% of nurses had been reportedly bullied (occasionally/ severely) at work. However, 65% of the participants reported overall job satisfaction (i.e., satisfied/ very satisfied) and rated their managers as relatively authentic. While bivariate and multivariate regression analysis revealed significant relationships among the three main study concepts, control/autonomy emerged as a central and common influencing factor. **Discussion:** Based on these findings, control/autonomy is key factor in the medical-surgical nursing environment. Therefore, strategies to decrease bullying and increase job satisfaction should focus on developing authentic leadership in nurse managers and increasing perceived control and autonomy for nurses working in medical-surgical areas. Further studies with more diverse nursing populations are needed to support this novel research evidence.

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CHAPTER I: INTRODUCTION

The nursing shortage is an escalating healthcare problem (Buchan & Aiken, 2008), with global turnover rates reportedly as high as 21% per year (Hayhurst et al., 2005). While there are multiple reasons for nurse turnover, job dissatisfaction is a frequently reported predictor of why nurses leave their organizations (Aiken et al., 2002; Chen-Chung et al., 2003; Lu et al., 2012; McCarthy et al., 2007). Empirical evidence consistently suggests that nurses on medical and surgical, or combined medical-surgical units have lower job satisfaction than nurses in other areas (Gowell & Boverie, 1992; Ingersoll et al., 2002; Kalisch et al., 2010; Shields & Wards, 2001; Wakefield et al., 1988). Furthermore, nurses on medical/surgical units, along with critical care areas, have higher turnover rates than other nursing units (Ingersoll et al., 2002; The HSM Group, 2002). High turnover affects economic, patient, and nursing outcomes.

Job satisfaction is one of the most studied concepts in organizational behavior research (Lu et al., 2012). A recent resurgence of interest in nursing job satisfaction corresponds with the burgeoning nursing shortage and consequent increase in job dissatisfaction among nurses (Albaugh, 2005). Based on national survey data (N=1002), American Medical Association (AMN, 2011) Healthcare reported an increasing number of nurses (from 34% to 42%) who were not satisfied in their jobs within only a one year period. The decrease in job satisfaction is significant because almost half of respondents in 2011 said they would like to change employers as compared to 33% in 2010 (AMN, 2011).

While there are many reported reasons for the discouraging trend in job satisfaction for nurses, team collaboration and working relationships have been documented as major predictors of job satisfaction (Adams & Bond, 2000; Aiken et al., 2001; Gifford et al., 2002). Workplace

relationships play a key role in how nurses perceive their work environments; unfortunately, convincing research evidence indicates that many nurses work in hostile environments (Kaye, 1996). Bullying is a key factor in hostile work environments. According to Lewis (2006), 80% of nurses will experience bullying in their careers. In a national survey of registered nurses (RNs), licensed practical nurses (LPNs), and registered psychiatric nurses (RPNs) in Canada (N=18,676), the Canadian Nurses Association (CNA; 2011) found that 44% of female nurses and 50% of male nurses reportedly had been exposed to hostility from people with whom they work**.** Although these numbers are alarming, they may actually underestimate the severity of the problem. Bullying is often underreported because of fear of retaliation, lack of knowledge of policies against bullying, different ways in which bullying is defined and bullying behaviors being ignored by those who have the power to address such behaviors, namely: managers (Cleary et al., 2010; Vessey et al., 2009).

Managers have been recognized as key players in preventing, recognizing, addressing, and controlling bullying behaviors. Moreover, certain leadership attributes among nurse managers have been attributed to a negative work environment (Upenieks, 2003). In fact, researchers have found that leadership styles exhibited by managers are significant contributing factors to job satisfaction and the nurses' intent to leave (Loke, 2001). However, there is minimal research regarding staff nurse perceptions of leadership styles and bullying. The overall purpose of this thesis was to explore the relationship between job satisfaction, bullying, and authentic leadership among medical-surgical nurses. The purpose of this chapter is to provide an overview of the statement of the problem, as well as the significance this study.

Statement of the Problem

Alarming numbers of nurses are leaving their jobs, thus contributing to the severe worldwide nursing shortage. In 2007, Canada experienced a shortage of approximately 11,000 RNs; it is predicted that this shortage will increase to 60,000 RNs (Cowden et al., 2011). Consequences of nursing shortages include: patient mortality (Aiken et al., 2002), compromised patient care (Blegen & Vaughn, 1998), inadequate staffing ratios (Kleinman, 2004), decreased productivity, poor work environments, patient and nurse dissatisfaction and increased cost associated with recruiting, hiring, and orienting (Erenstein &McCaffrey, 2007; Jones, 2008).

Some turnover is anticipated, especially on medical-surgical units because this is where many nurses start their careers; however, turnover rates reportedly reach up to 47% on medical/surgical units, while only 18% of critical care nurses plan to leave their units (McCarthy et al., 2007). Furthermore, nurses who work in high turnover environments report higher levels of stress, related to frequent training of new staff (Erenstein & McCaffrey, 2007). As well, nurse turnover is costly; Jones (2008) found nurse turnover in the United States (US) cost $82, 000-$88, 000 per nurse. In a similar study, Pendry (2007) found that the cost to recruit, hire, and orient one medical/surgical nurse costs $92, 000. In a time of a nursing crisis, retention of nurses is key to the survival of healthcare (Kwak et al., 2010). Therefore, factors that are associated with nurse turnover must be a priority for nursing administrators.

Job satisfaction has been identified as a key influencing factor in nursing turnover (Lu et al., 2012). Therefore, as healthcare institutions face nursing shortages, consideration of factors associated with job satisfaction is essential because a profound consequence of job dissatisfaction is turnover (Lu et al., 2002; O'Brien-Pallas et al., 2010). Addressing the nursing

shortage must be focused on maximizing the desirability of the work environment, with the intent to improve job satisfaction among nurses (Ingersoll et al., 2002). Job satisfaction has been negatively correlated with intention to leave an organization and the profession (Lu et al., 2002) and evidence suggests that it is related to organizational, professional, and personal variables (Lu et al., 2012).

However, the literature reflects inconsistencies in the factors that influence job satisfaction among nurses. Despite some discrepancies throughout the job satisfaction literature, medical-surgical nurses are consistently one of the least satisfied groups of nurses (Cronin-Stubbs & Rooks, 1985; Ingersoll, et al., 2002; Wakefield et al., 1988). This is particularly concerning because the majority of nurses (35%) are medical/surgical nurses (Spratley et al., 2000). Additionally, medical/surgical nurses have higher turnover than do nurses on other types of units; however, sociological evidence reveals that units differ in social milieu and multidisciplinary team relations (Adams & Bond, 1997; Lu et al., 2012). This is of extreme importance because work relationships are one of the most significant factors influencing job satisfaction (Trovey & Adams, 1999).

Workplace bullying is a widespread phenomenon across many sectors; however, nurses are considered a higher-risk group for exposure to workplace violence (Hutchinson et al., 2010; Vartia & Hyyti, 2002). According to the research literature, bullying may have personal (i.e. individual), as well as organizational (i.e. professional) consequences. Personal consequences can be extremely serious, with a significant impact on the victim. Examples of personal consequences include headaches, stress, irritability, anxiety, sleep disturbance, excessive worry, impaired social skills, depression, fatigue, loss of concentration, helplessness, psychosomatic

complaints, post-traumatic stress disorder, and emotional pain (Cleary et al., 2010; Murray, 2008; Ramos, 2006; Yildirim, 2009).

Organizational consequences of bullying include staff turnover, decreased morale, decreased staff and patient satisfaction, loss of productivity, and cost associated with turnover (Cleary et al., 2010; Johnson & Rea, 2009; Murray, 2008; Woelfle & McCaffrey, 2007). Bullying may cost over $4 billion dollars yearly (Murray, 2008a), with indirect consequences to the organization, including absences from work, work related injuries, and jeopardized safe patient care (Johnson, et al., 2009; Murray, 2008).

Bullying arises from organizational cultures that tolerate these negative behaviors in the workplace. Studies of bullying have suggested that although personal factors may contribute to bullying in workplaces, organizational factors are the main cause for workplace bullying (Lewis, 2006). A manager's leadership style is a crucial factor contributing to the work environment because although organizational factors may be interrelated, managers ultimately have the power, responsibility, and control of many of the organizational factors that fuel bullying. For example, potential job stressors such as: workloads, lack of opportunities for promotion, non-flexible work schedules, role conflict, role ambiguity, team collaboration, and work control/autonomy are influenced by leadership styles (Hauge et al., 2007; Laschinger et al., 2012; Upenieks, 2003).

Several studies report that some managers use bullying as a style of management (Hoel & Beale, 2006; Hutchinson et al., 2006; Ironside & Seifert, 2003; Johnson 2009; Lutgen-Sandvik et al., 2007). Furthermore, there are certain leadership styles that are associated with higher incidences of bullying behaviors among the staff, for example; autocratic leadership style is regarded as a direct forerunner of bullying and bullying may be regarded as part of the

organizational culture in these workplace environments (Agervold, 2009). Effective leadership skills have been demonstrated to enhance job satisfaction and encourage staff nurse retention (Bratt et al., 2000); however, there is limited evidence regarding the specific managerial leadership behaviors that are associated with bullying and the consequent impact on job satisfaction in the nursing workplace (Kleinman, 2004).

Significance

Numerous studies have demonstrated the link between healthy work environments, nurse satisfaction, and nurse retention (Aiken & Patrician, 2000; Cohen et al., 2009; McCarthy et al., 2007; O' Brien-Pallas et al., 2001; Sawatzky & Enns, 2012). However, few researchers have explored the relationship between the specific behavior of workplace bullying, nurse job satisfaction, and a manager's leadership style, specific to medical-surgical units. Many studies of violence have focused on mental health (Graydon et al., 1994), and emergency settings (Whittington et al., 1996); however, few studies have addressed general medical/surgical units as a cause of concern for workplace bullying. The need for more studies on bullying and medical-surgical units is crucial because the majority of hospital nurses are medical-surgical nurses and the few bullying studies that have isolated various types of units have found that medical/surgical units have the highest levels of bullying (Vessey et al., 2009).

Leadership styles influence the work environment, job satisfaction, and retention (Failla & Stichler, 2008). Previous research has demonstrated that leadership styles are one of the most significant organizational factors contributing to workplace bullying (Einarsen et al., 1994; Hauge et al., 2007). Since managers are known to be the greatest perpetrators of bullying and

central to the role of a manager is leadership, it is important to explore the relationship between leadership styles and workplace bullying.

In summary, this chapter has highlighted the key components involved in the problem of the nursing shortage. These key components include: workplace bullying, job satisfaction, and manager's leadership styles. Escalating levels of bullying behaviors and decreasing job satisfaction among nurses highlight the significance of the problem. This is noteworthy because a major consequence of decreased job satisfaction is nurse turnover; thus, contributing to the nursing shortage. Furthermore, this section revealed that managers have the power to address workplace bullying and increase job satisfaction through effective leadership, especially on medical-surgical units where bullying is out of control. Therefore, the current study explored the relationship between workplace bullying, job satisfaction, and authentic leadership among medical-surgical nurses.

CHAPTER II: CONCEPTUAL FRAMEWORK

In this chapter, the primary concepts of the thesis study will be explored and defined. As well, theories and frameworks that are commonly used in relation to these concepts will be reviewed. Thus, sound rationale for selecting the Organizational Framework for Predicting Nurse Retention (OFNPR) to guide this study will be established. As this thesis study only addressed a component of the OFNPR, only concepts relevant to the current study are discussed.

Job Satisfaction

This section will provide an overview of the concept of job satisfaction. Furthermore, a job satisfaction definition will be determined based on the existing research, and previous job satisfaction theories will be explored. The overall goal is to establish the foundation for the study framework.

Job Satisfaction Defined.

Job satisfaction has been studied across numerous disciplines for over 80 years (Brief & Weiss, 2002; Stone, 1987); it has also played a central role in many theories of management and organizational research. Although there are inconsistencies in how job satisfaction should be defined, nonetheless, some descriptors have remained consistent over time. The majority of literature in this area concurs that job satisfaction is considered to be an attitude (Brief, 1998; Eagley & Chaiken, 1993; Lu et al., 2012; Weiss & Cropanzano, 1996; Weiss, 2002). In essence, an attitude is a tendency to act in a certain way due to both an individual's experience and temperament (Pickens, 2005). Furthermore, many studies reveal that there is an affective (i.e. emotional; Hulin & Judge, 2003; Locke, 1976; Lu et al., 2005; Tirmizi et al., 2008; Weiss & Cropanzano, 1996), a cognitive (i.e.evaluative; Hulin & Judge, 2003; Locke, 1976; Weiss &

Cropanzano, 1996), and a behavioral component (Hulin & Judge, 2003) involved in job satisfaction. Inconsistent variations of the job satisfaction concept can be related to individual perceptions of job satisfaction. Thus, inconsistencies in various definitions of job satisfaction may be related to personal experiences, values, and beliefs.

One of the most widely used job satisfaction definitions in organizational research is Locke's (1969) description of this concept. Locke defined job satisfaction as a "pleasurable emotional state resulting from the appraisal of one's job as achieving or facilitating one's job values" (p.317). Moreover, much of the literature supports that job satisfaction is about a relationship between an employee's intrinsic (i.e. person factors) and extrinsic factors (i.e. work environment factors; Adams & Bond, 2000; Ellickson & Logsdon, 2001; Moynihan & Pandey, 2007; SaifudDin et al., 2010).

Global/facet perspective. Some researchers view job satisfaction as either a global perspective (Klingner, 2009; Scarpello & Campbell, 1983; Wanous et al., 1997), in which actual overall job satisfaction is tainted with individual experiences (Hulin & Judge, 2003), or a facet perspective, which encompasses specific factors that cause job satisfaction. Lu et al. (2012) explain that the global approach is used when the overall attitude of job satisfaction is of interest and the facet approach is used to identify which parts of the job produce satisfaction. Interestingly, researchers were finding that global measures and various facet measures did not have the same job satisfaction outcome (Lu et al., 2012; Scarpello &Campbell, 1983; Smith et al., 1969). In other words, the global measure is not the sum of the separate facet questions.

Some researchers argue that from a facet perspective the concept of job satisfaction is comprised of various component parts (Judge & Hulin, 1993; Nolan et al., 1995; Smith et al.,

1969; Zheng & Lie, 2010a). Although the facet perspective uses empirically tested facets, that prove to be valid and reliable, researchers are still unsure of the actual causes of job satisfaction. Additionally, multiple-item facet scales may neglect some components of a job that are important to that particular employee (Highhouse & Becker, 1993; Ironson et al., 1989; Klingner, 2009; Wanous et al., 1997; Weiss, 2002). Moreover, what is the point of measuring only "some" facets that the researcher considers special or most talked about because the frequency of facets are not necessarily equivalent to importance (Weiss, 2002).

In essence, the most common causes of job satisfaction have been evaluated in nursing literature, but there is still room for discrepancies in perception of what are considered the "key" factors (Highhouse & Becker, 1993; Scarpello & Campbell, 1983). However, some common factors that affect job satisfaction include person factors, such as demographics including age, years of experience, education, gender, culture, and unit type. Organizational factors included physician/nurse collaboration, nurse/nurse collaboration, nursing management, professional practice, resources and staffing, positive scheduling climate, and nursing competency.

A key component of the global facet approach is that it revolves around perception. Individual perception is how an individual interprets the stimuli into something meaningful to them, based on prior experiences (Lindsay & Norman, 1977; Picksons, 2005). Individual perception is based on beliefs, experience, or attitudes (Sherif & Cantril, 1945). In other words, what one individual perceives as valuable may not be valuable to another individual. Studies report that individuals obtain information from sources external to them (e.g. managers, co-workers) and from self-generated evaluations (e.g. individual experiences; Ilgen et al., 1979; Ivancevich & McMahon, 1982; Margareth et al., 1995). Thus, humans reflect on what is important to them based on their life experiences (Pickens, 2005).

In summary, although the concept of job satisfaction has numerous variations of how it can be defined, research consistently reports that job satisfaction is an attitude and it has affective, cognitive, and behavioral components. Furthermore, these components are susceptible to individual perception; thus, perception was central to choosing a definition, and measure for this study. Therefore, Locke's (1969) definition of job satisfaction as a "pleasurable emotional state resulting from the appraisal of one's job as achieving or facilitating one's job values" (p.317) was used for this current study.

Job Satisfaction Theories

This section begins with a historical perspective, followed by an overview of the key job satisfaction theories, including Abraham Maslow's theory of "Hierarchy of Needs," Herzberg's two-factor Motivation-Hygiene Theory of job satisfaction, and causal models of job satisfaction. By exploring job satisfaction theories, rationale will be established for selecting the primary framework for this study.

Historical perspective. Historically, theories of job satisfaction emerged in management, beginning with Frederick Winslow Taylor, who contributed significantly to the emergence of job satisfaction in his 1911 book "Principles of Scientific Management." Taylor was a mechanical engineer who sought to improve industrial efficiency. Taylor contended that there are numerous elements of scientific management, which involve a complete revolution of mental attitude. Taylor's elements included specialized supervision standardization of tools and work methods, in which he emphasized the importance of intimate and friendly cooperation between the management and employee. Moreover, Taylor wrote about how money was the biggest motivator for job satisfaction (e.g. bonuses for good performance). In essence, Taylor

wrote about the development of a true science, in which he believed there was only one method of work that maximized efficiency: the gradual substitution of science for the "rule of thumb." The initial use of Taylor's scientific management by organizations increased productivity; however, Taylor's approach was criticized for dehumanizing the worker, through the allocation of directing what has to be done, how it is to be done, and the exact time it is to be done. Furthermore, Taylor's approach to motivation started and finished with monetary incentives, such as pay. Unfortunately, workers became exhausted and dissatisfied with this approach, which led to new investigations of job satisfaction.

Elton Mayo and associates of Harvard Business School (1924-1933) challenged Taylor through the Hawthorne studies, which were among the most significant precursors to the study of job satisfaction. These studies primarily focused on the effects of various conditions on workers' productivity. The results of these studies indicated that changes in work conditions could increase productivity (i.e. the Hawthorne Effect). These results also indicated that there were other factors influencing job satisfaction besides pay. In these seminal studies, it became understood that working conditions influenced employee's job satisfaction.

The numerous theories on job satisfaction fall into the categories of 1) Situational theories: job satisfaction results from the nature of one's job or aspects of the environment, 2) Dispositional approaches: job satisfaction derived from the personalogical makeup, 3) Interactive theories: job satisfaction is derived from both situational and personalogical factors (Judge & Klinger, 2008).

Maslow's hierarchy of needs. Research in the area of job satisfaction continued to develop more fully and one of the first motivation theories that laid the foundation for job

satisfaction research was Abraham Maslow's (1954) theory of "Hierarchy of Needs" (Saif et al., 2012). Maslow's Hierarchy of Needs is a good example of a dispositional approach that is derived from the idea that job satisfaction is from the personalogical makeup of an employee. Maslow contended that a person's motivational requirements could be ordered in a hierarchy. According to Maslow, every human is capable of moving up the hierarchy of needs; however, only 2% will meet the highest need, of becoming self- actualized. Maslow reported that once a given level of need is satisfied, the next higher level of need has to be activated in order to satisfy an individual. Maslow (1943) identified five levels of needs: 1) physical needs (e.g. food, clothing), 2) safety needs (e.g. physical protection), 3) social needs, 4) esteem/achievement needs (e.g. prestige given by others), and 5) self-actualization needs (e.g. self-fulfillment and accomplishment though personal growth). Maslow's research built on the Hawthorne studies in that he continued to explore the link between working conditions, job satisfaction, and productivity.

A limitation of Maslow's theory is that it was formulated on a very small sample size of 21 people. Additionally, Maslow only examined people whom he considered to be self-actualized, which is questionable from a scientific perspective because he used his perception of what he considered to be self-actualization. Furthermore, Maslow's theory has been criticized because he assumes that lower needs must be met in order to achieve the higher needs; however, this is not true; for example, people without shelter are still capable of family/love. Moreover, this theory does not include the external work environment factors, such as managers; therefore, is not an appropriate framework for a workplace study of job satisfaction.

Herzberg's motivation-hygiene theory. One of the most prevalent theories in the job satisfaction literature is Herzberg's (1959) two-factor job satisfaction theory. In his book, "Work

and the Nature of Man," Herzberg contends that man has two sets of needs, which are basic animal needs. He argues that people will be motivated to achieve these basic needs because they are unhappy without them, but once achieved, the satisfaction is only temporary, and the drive for deeper needs is sought, which is the need to grow psychologically.

One of the first research studies to test this theory was a qualitative study in which Herzberg and colleagues (1959) interviewed accountants and engineers from different companies in Pittsburgh (N=200) to test the theory that man has two sets of needs. Herzberg and colleagues found that job satisfaction consisted of two separate independent dimensions: job satisfaction and job dissatisfaction. Herzberg concluded from this study that there are job-satisfiers (i.e. motivating factors) related to the job contents and job-dissatisfiers (i.e. hygiene factors) related to the job context (Saif et al., 2012). Motivators include factors related to the actual work, such as: achievement, recognition, stimulating work, responsibility, advancement/promotion and personal growth, while hygiene factors include external work environmental factors such as: pay/benefits, policy/administration, working relationships, supervision, job security, and working conditions (Wilson & Zhang, 2010).

The most unique aspect of this theory is the distinction of job satisfaction and dissatisfaction as two separate concepts, rather than viewing these concepts on a continuum. Hence, according to Herzberg, motivators increase job satisfaction, but have no influence on dissatisfaction; similarly a decrease in hygiene factors impacts dissatisfaction but does not influence job satisfaction. However, this theory has been discounted by more recent research. For example, ineffective leadership styles (hygiene factor) reportedly decrease job satisfaction (Hoel & Cooper, 2000; Huber, 2006). On the other hand, effective leadership improves job satisfaction (Abualrub & Alghamdi, 2012). Another example, that challenges this theory, is that

lack of recognition from managers causes job dissatisfaction (Duffield et al., 2010). Likewise, House and Wigdor (1967) contend that although intrinsic aspects of jobs are shown to be more frequently identified as satisfiers, lack of achievement and recognition can also be dissatisfiers.

Another limitation to Herzberg's theory is the overgeneralization of the theory due to the fact that evidence was based on a limited sample of accountants and engineers. Additionally, certain factors can cause job satisfaction for one individual and job dissatisfaction for another person (House & Wigdor, 1967); therefore, individual perception is an important factor to consider.

In summary, although this theory provided a good theoretical foundation for job satisfaction, more recent literature validates that job satisfaction/dissatisfaction is on a continuum, rather than two distinct entities.

Causal Models of Job Satisfaction

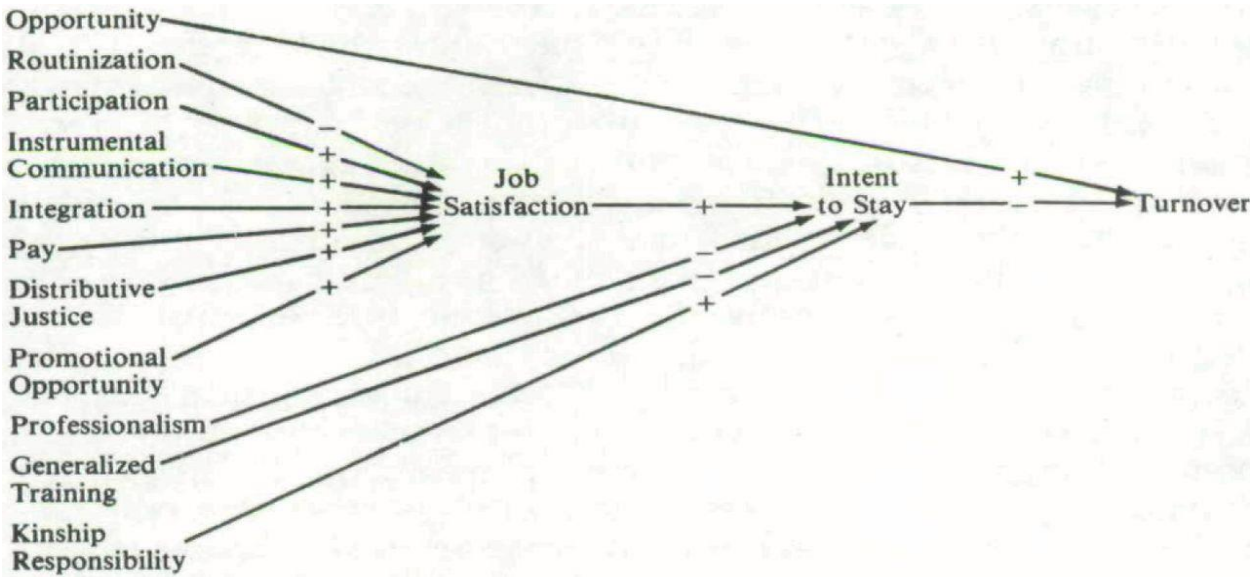
Historically, the earliest models of workplace turnover involved the notion that job dissatisfaction caused turnover and research questions revolved around individual characteristics (Holtom et al., 2008). More recent models of job satisfaction tend to focus more on antecedents and outcomes of job satisfaction, with job satisfaction/dissatisfaction on a continuum (Larrabee et al., 2003; O'Brien-Pallas et al., 2001; Price & Mueller, 1981; Tzeng, 2002).

The Causal Model of Nursing Turnover. Prior to the1980's, research in this area mainly focussed on single antecedents to job turnover (March & Simon, 1958; Porter & Steers, 1973). It was not until Mobley (1977) proposed a sequence of steps employees go through before quitting their jobs, which laid a foundation to intermediate linkages to turnover. Furthermore, this notion led Price and Mueller (1981, 1986) to develop a comprehensive

structural model, the Causal Model of Nursing Turnover, which acknowledged antecedents of job satisfaction and intent to leave and added organizational commitment as a mediator between these two variables. Essentially, this gave rise to the causes of job satisfaction as important factors for turnover research. Thus**,** job satisfaction research into the mid-1980s and early 1990s involved an increase in consideration of contextual variables (Holtom et al., 2008). The contextual variables were separated into two categories: organizational and person-context variables with an emphasis on employees' relations with their environment (Holtom et al., 2008).

Price and Mueller's model, based on Price's (1977) earlier work, was one of the first nursing turnover models to focus on antecedents of job satisfaction and intent to leave, with the addition of organizational commitment. More specifically, Price and Mueller's (1981) model identified the relationship between 11 determinants of turnover, the intervening factors (e.g., job satisfaction and intent to stay), and the outcome of nursing turnover. The Causal Model of Turnover (Price & Mueller, 1981; see Figure 1) contends that the determinants cause variations in turnover. The 11 determinants include: opportunity, routinization, participation, instrumental communication, integration pay, distributive justice, promotional opportunity, professionalism, generalized training, and kinship responsibly (Price & Mueller, 1981). A major contribution to Price's original model was the addition of "intent to stay" as an intervening variable between job satisfaction and turnover (Price & Mueller, 1981) because commitment was found to be a mediator between job satisfaction and turnover.

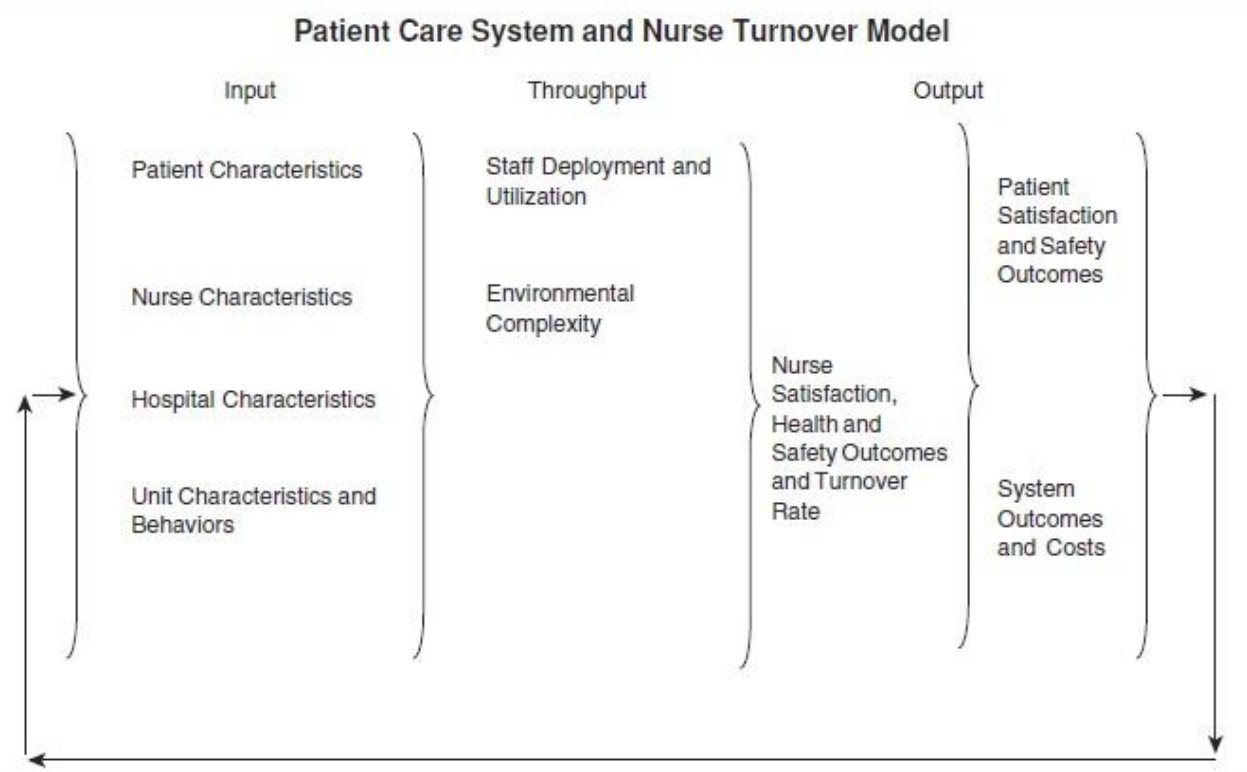
Figure 1. The Causal Model of Turnover. Source: Price & Mueller, 1981.



The Patient Care System and Nurse Turnover Model. Modern theories on turnover focus on stress and change related attitudes, with a significant emphasis on contextual variables, and interpersonal relationships (Holtom et al., 2008). For example, O'Brien-Pallas et al.'s (2008), Patient Care System and Nurse Turnover Model (PCSNT Model; see Figure 2) contends that system inputs (e.g. characteristics of patients, nurses, the nursing unit, and organization) interact with throughput (e.g. environment, staff utilization, and turnover rate) to produce system outputs (e.g. job satisfaction). An appealing feature of this model is that it focuses on consequences of nurse turnover, as opposed to determinants, which is what much of the turnover literature focuses on. Moreover, this model has been tested in numerous Canadian settings (O'Brien-Pallas et al., 2001; O'Brien-Pallas et al., 2010). Although this model has desirable aspects, such as highlighting hospital characteristics as important to nurse satisfaction;

nonetheless, it does not specifically focus on nursing management (O'Brien-Pallas et al., 2010). One shortcoming of this framework is that it has generally not been used in studies that have focused specifically on medical/surgical units, with the exception of one study (O'Brien-Pallas et al., 2006b), which explored job satisfaction in medical/surgical nurses across multiple countries. O'Brien-Pallas et al., (2006) identified that subsequent research needs to clarify how perspectives differ between nurses and nurse executives in terms of priorities for nurse retention in practice settings; thus, establishing additional rationale for current study.

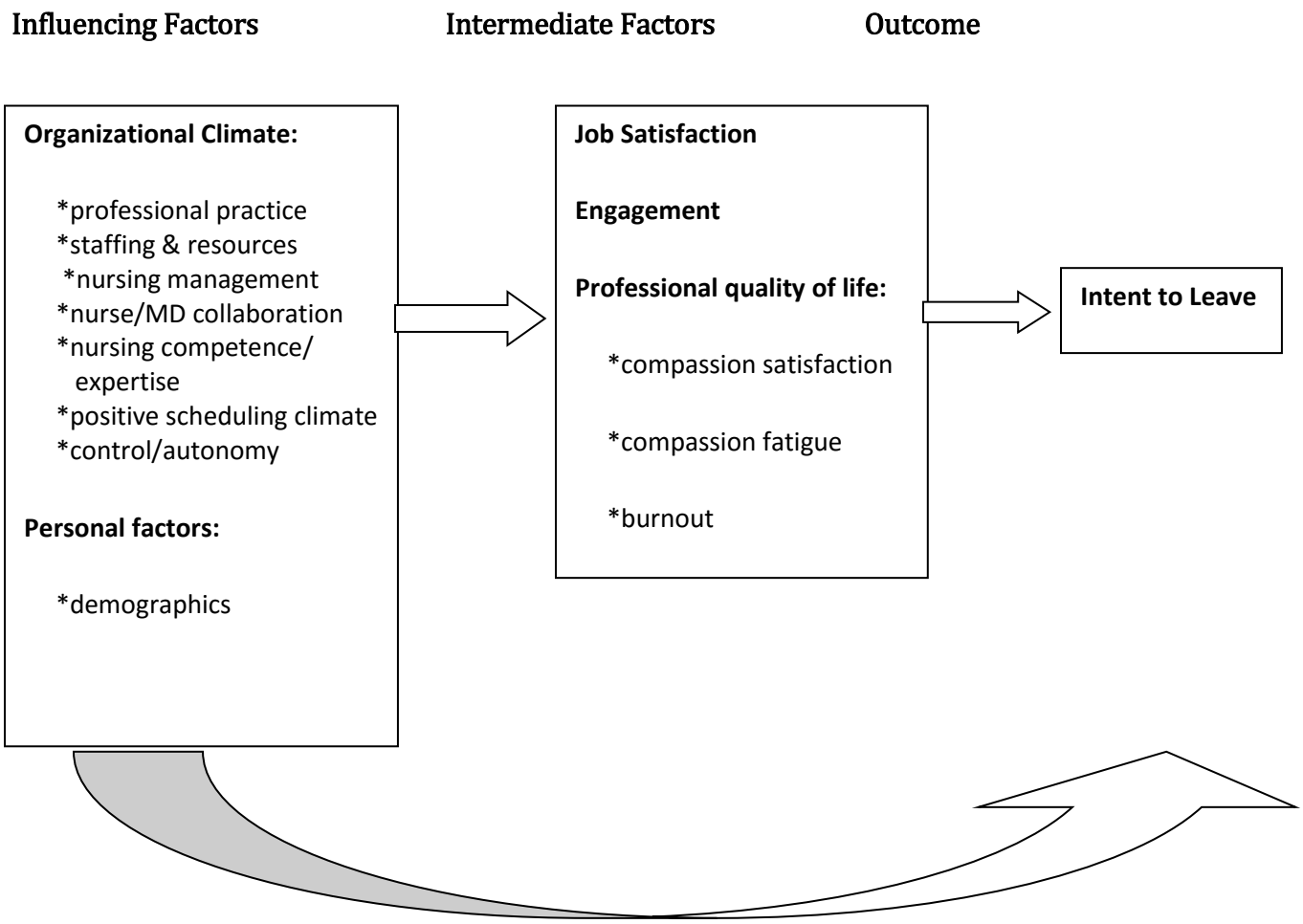
Figure 2. The Patient Care System and Nurse Turnover Model. Source: O'Brien-Pallas et al. 2008**.**



Based on the results from previous turnover models (Larrabee et al., 2003; O'Brien-Pallas et. Al., 2001; Price & Mueller, 1981; Tzeng 2002) and a solid foundation of previous research of turnover, a more contemporary model was developed by Sawatzky and Enns (2012): the Organizational Framework for Predicting Nurse Retention (OFPNR).

Organizational Framework for Predicting Nurse Retention. Sawatzky and Enns (2012) developed the OFPNR (see Figure 3), to provide a theoretical context for predicting nurse retention. This framework has been utilized in a recent study of emergency nurses (Sawatzky & Enns, 2012). The OFNPR represents the conceptual links between influencing factors, intermediary factors, and intent to leave. Components of previous turnover theories were integrated to form this framework, including O' Brien-Pallas et al.'s (2001) input (i.e. person factors), throughput (i.e. organizational factors), and output (job satisfaction). Furthermore, Price and Mueller (1981)'s ideas about how determinants cause variation in turnover were also integrated in the OFNPR.

*Figure 3***.** The Organizational Framework for Predicting Nurse Retention, source: Sawatzky & Enns, 2012.


Influencing Factors
Intermediate Factors
Outcome
Organizational Climate:
*professional practice
*staffing & resources
*nursing management
*nurse/MD collaboration
*nursing competence/ expertise
*positive scheduling climate
*control/autonomy
Personal factors:
*demographics
Job Satisfaction
Engagement
Professional quality of life:
*compassion satisfaction
*compassion fatigue
*burnout
Intent to Leave

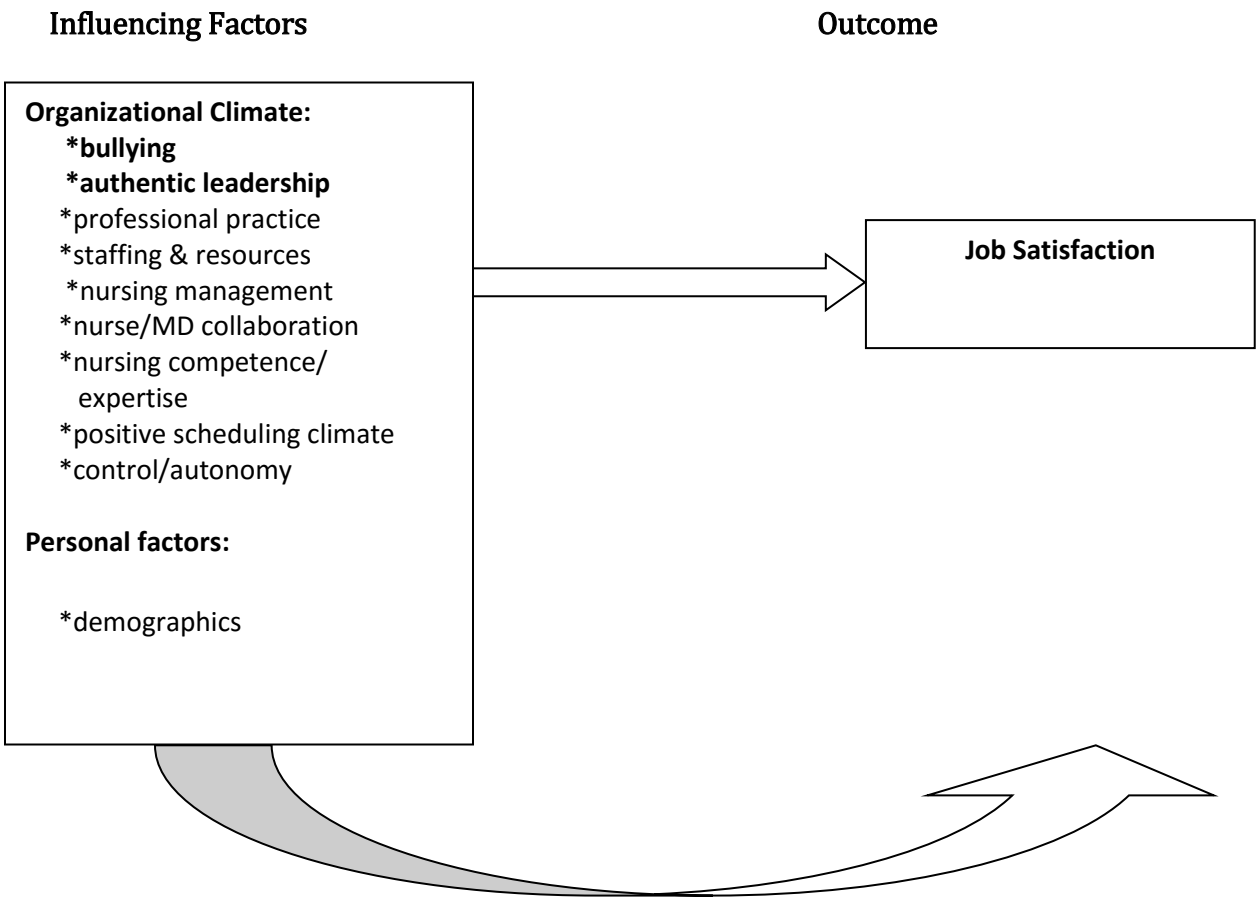
According to the OFNPR, influencing factors may predict intention to leave either directly or indirectly by their effect on the intermediary factors (e.g. job satisfaction). The influencing factors include the organizational climate and person (i.e. personal/demographic) factors. Specific to organizational climate, Sawatzky and Enns' (2012) research is grounded in the Nursing Organizations Alliance's (2004), nine principles and elements of a Healthful Practice Work Environment: collaborative practice culture; communication-rich culture; culture of accountability; presence of adequate numbers of qualified nurses; presence of expert, competent, credible, visible leadership; shared decision-making at all levels; encouragement of professional practice and continued growth/development; recognition of the value of nursing' s contribution; and recognition by nurses of their meaningful contribution to practice.

Intermediary factors may intercede with influencing factors in the decision to stay or leave the organization, or intermediary factors may have a direct impact on the decision to stay or leave the organization. Intermediary factors include job satisfaction, engagement, professional quality of life (i.e. compassion satisfaction, compassion fatigue and burnout) and caring.

The OFPNR was the most appropriate choice for this study because it revolves around the idea that there are multiple factors that influence a nurse's job satisfaction. However, this model also allows researchers to focus on a particular area, or add other influencing factors and adapt the model accordingly. Therefore, this framework was modified to accommodate two additional influencing factors. This thesis study was part of a larger study, which encompassed all the concepts within this framework. However, the thesis project focused on bullying and authentic leadership as influencing factors, and job satisfaction as the outcome (see Figure 4:

Revised Framework). Thus, bullying and leadership styles will be discussed in the next section because they are central concepts in this thesis study.

*Figure 4***.** The revised version of the Organizational Framework for Predicting Nurse Retention, which includes bullying and authentic leadership as influencing factors, with job satisfaction as the outcome.



Summary. In summary, job satisfaction is a complex concept and a key component to job satisfaction is individual perception. Job satisfaction can be defined through a global perspective or facet perspective; however, overall satisfaction was of interest to this thesis study, therefore, a global definition was most appropriate. Theories of job satisfaction in nursing did not flourish until the 1970's when there was a critical shortage of nurses. Theories include: Maslow's Hierarchy of Needs, Herzberg's Motivation-Hygiene Theory, the Causal Model of Nursing Turnover, the Patient Care System and Nurse Turnover Model, and finally the OFNPR. Although each of the theories has its strong points, the OFNPR was deemed as the most appropriate for this study because it encompasses the strengths of the other models.

Bullying

This section will provide an overview of the concept of bullying. Furthermore, a bullying definition will be elicited from existing research and previous bullying theories will be explored. The overall goal was to establish a definition that could be used for the current study.

Workplace Bullying Defined

Historically, a psychiatrist, Carroll Brodsky, conducted one of the first studies of workplace harassment in the United States in 1976; however, at that time Brodsky's work stirred little interest. Eventually, studies began to explore antecedents to workplace violence (Andersson & Pearson, 1999; Keashyly, 1998), and in the 1980s an increased public consciousness of rights of employees emerged. In the early 1980s, a nursing professor, Helen Cox (1991) began studying verbal abuse in healthcare as a factor that drove nursing students to quit. However, the actual concept of workplace bullying emerged from studies on bullying among children in schools, when similarities between bullying in children and adults were recognized (Calvert, 2008).

Everyday conflict is normal and it is important to distinguish between normal conflict and bullying behaviors to better understand bullying (Olweus, 1993). Normal conflict includes: occasional, not pre-planned, in the heat of the moment, genuine upset to both parties, trying to work things out, no trying to take something from someone, both parties admit some responsibility, and effort to solve the problem by both parties (Olweus, 1993). On the other hand, bullying includes: repeated happening, premeditated, on purpose, intentional, planned, person being bullied is more upset, trying to be the one in control, want to take power or possessions from someone, blame is laid on the person who is bullied, and no effort to solve the problem by the person bullying (Olweus, 1993).

Workplace bullying was first introduced in the Scandinavian countries in the mid-1980s by Norwegian and Swedish organizational psychologists (Leymann, 1986; Matthiesen et al., 1989; Kile, 1990). Heinz Leymann (1986) originally defined bullying as ongoing conflict in which the victim is subjected to two or more negative incidents on at least a weekly basis, over at least a 6-month period. Additionally, workplace bullying involves individuals who, over a prolonged period of time, perceive themselves to be the object of negative treatment, in which they cannot defend themselves; hence, there is a power imbalance (Leymann, 1986). Similarly, Einarsen et al. (2003) defined, bullying as:

> "… harassing, offending socially excluding someone or negatively affecting someone's work tasks. To be considered bullying, the behavior must occur repeatedly and regularly (e.g. weekly) and over a period of time (e.g. about six months). Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts" (p. 15).

Workplace bullying is a challenging concept to define because it is subject to variation in personal perceptions (Quine, 2001). Nonetheless, the literature consistently reports that definitions of

bullying generally share four common elements. First, bullying is defined in terms of its impact on the recipient, in which case individuals are subjected to a range of intimidating behaviors that make them feel bullied (Einarsen et al., 2003; Qunie, 2001; Zapf & Gross, 2001). Secondly, bullying must have a negative effect on the individual; for example, the victim feels upset because of being humiliated. Thirdly, bullying behavior must be persistent (Einarsen et al., 2003; Qunie, 2001; Zapf & Gross, 2001); for example, bullying must be ongoing. Finally, bullying is a unique form of other acts of aggression because of the nature of aggressive acts and the imbalance of power between the victim and the bully (Kokkinos & Kipritsi, 2012).

Types of Bullying

According to Qunie (2001) there are three main types of bullying: direct physical, verbal, and indirect. Examples of direct bullying are aggressive acts directly against the victim (e.g. teasing or threats); Examples of physical bullying include tripping, taking things from another, kicking, pushing, and shoving (Bjorkqvist et al., 1992). Verbal bullying may include such behaviors as name-calling, profanity, trying to make someone look stupid, showering abuse, and arguing (Bjorkqvist et al., 1992). Indirect bullying, which is also known as relational bullying, consists of more subtle behaviors such as eye rolling, and other negative gestures, gossiping, suggesting shunning of the other, spreading rumors, breaking contact with a person in question, social exclusion and becoming friends with someone else as revenge (Bjorkqvist et al., 1992; Kokkinos & Kipritsi, 2012). Furthermore, there are work-related and person-related acts of bullying. Work related acts make it difficult for employees to work; for example, acts that affect one's reputation at work (Leymann, 1990). Person related acts are directed against an individual; for example, rumour spreading, teasing (Einarsen, 2000).

Furthermore, Rayner and Hoel (1997) presented 5 main categories of bullying, which included: 1) *threat to professional status*, including: persistent attempts to belittle and undermine

ones work, persistent unjustified criticism and monitoring of ones work, persistent attempts to humiliate one in front of colleagues, intimidating use of discipline/competence procedures; 2) *threat to personal standing*, including: undermining one's personal integrity, destructive sarcasm, verbal and non-verbal threats, making inappropriate jokes about one, persistent teasing, physical violence, violence to property; to 3) *isolation*, including: withholding necessary information from one, freezing out/ignoring/excluding, unreasonable refusal of applications for leave, training or promotion; 4) *overwork*, including: undue pressure to produce work, setting of impossible deadlines; 5) *destabilization*, including: shifting goalposts without telling you, constant undervaluing of your efforts, persistent attempts to demoralize one, removal of areas of responsibility without consultation. Overall, these actions in the workplace maybe subtle and tend to be consistent with other researchers who describe workplace bullying.

Summary

In summary, Einarsen's et al. (2003) definition of workplace bullying was used in this research, as it demonstrates the most common characteristics of workplace bullying. There are different types of bullying including: direct physical, verbal, and indirect. Furthermore, there are work related and person related acts of bullying. Overall, bullying behaviors present in different ways and these behaviors are important to acknowledge because although they are often subtle, they influence nurse job satisfaction.

Leadership Styles

This section will provide an overview of the concept of leadership and common leadership theories. Furthermore, based on the existing literature, different leadership styles will be explored and defined. Finally, the overall goal was to substantiate authentic leadership the most appropriate leadership style to include in the current study.

Health care organizations are social systems where human resources are one of the most important factors for ensuring quality of care. Such organizations need effective managers to lead their employees through chaos and change. Leadership refers to how leaders influence change and induce followers (Ellis & Hartly, 2009). Healthy work environments do not naturally occur; they are fostered by strong nurse leaders (Cohen et al., 2009; McGuire & Kennerly, 2006). Evidence suggests that the leadership by nurse managers directly impacts the performance of hospital nursing units (Casida & Parker, 2011; Kleinman, 2004). Effective leadership is associated with increased job satisfaction, (Shader et al., 2001), which is key to the retention of nurses (Ribelin, 2003), and also thought to be one of the main antecedents influencing workplace bullying (Einarsen et al., 2003). Although there are numerous leadership styles, only the most common will be defined, including what the literature describes as: non-effective leadership styles and effective leadership styles.

Non-Effective Leadership Styles

Laissez-faire leadership. Laissez-faire leadership is defined as a leadership style in which the leader exhibits frequent absence and lack of involvement during critical situations (Avolio & Bass, 2002). For example, laissez-faire leaders do not give feedback to followers, and put minimal effort to meet employees' needs (Chemers, 1997).

Autocratic leadership. Autocratic leaders are described as controlling, power-oriented, and closed minded (Bass, 2008). For example, autocratic leaders tell subordinates what to do and, make decisions in a dictatorial way.

Effective Leadership Styles

Transformational leadership involves establishing oneself as a role model by gaining the trust of followers. Transformational leaders state future goals and develop plans to achieve them (Bass, 1985, 1998). Transformational leadership is described in 5 domains: idealized influence (i.e., leaders are perceived as confident, powerful, and focused on ethics), idealized behaviors (i.e., leaders

manifest actions centered on values, beliefs, and sense of mission), inspirational motivation (i.e., leaders clearly and confidently communicate a vision and inspire followers to transcend their own-self-interest to achieve the vision), intellectual stimulation (i.e., leaders foster an environment in which beliefs can be safely challenged and empower others to take risks), and individual considerations (i.e., leaders relate to followers on an individual level, an work to get them to develop full potential).

Transactional leadership involves managing in the more conventional sense of clarifying subordinate responsibilities, by rewarding them for meeting objectives, and correcting them for failing to meet objectives (Avolio, 1999; Bass, 1998; Burns, 1978). Transactional leadership is described in 3 domains: contingent reward (i.e., leaders provide reward if employee completes task) (Kirby et al., 1992), management-by-exception (active) (i.e., leaders watch followers for mistakes and then correct them (Chemers, 1997), and management-by-exception (passive) (i.e., leaders allow followers to do their jobs on their own and only intervene if problems or standards are not met) (Kirby et al., 1992). A key difference between transformational and transactional leadership is that the transactional leader appeals to subordinates' self-interest by establishing exchange relationships with them. Although, both are empirically separable, these two types of leadership are both displayed by effective leaders (Eagly, et al., 2003).

Full-Range Model of Leadership (Bass & Avolio, 2000), which includes characteristics of transformational, transactional, and laissez-faire leadership. However, limitations of this model include important leader behaviors that are overlooked, such as consulting, empowering, recognizing, clarifying roles and objectives, and short term planning (Bycio et al., 1995; Carless, 1998; Rafferty & Griffin, 2004; Yukl, 1999a). Furthermore, according to this theory, ideal leaders must be charismatic, in other words, good leaders must be nice people. Hence, this model is not appropriate because charismatic leaders do not necessarily have the traits to deal with workplace bullying and job

dissatisfaction. Authentic leadership is an emerging phenomenon in the nursing literature and has been minimally investigated in healthcare. Historically, authenticity dates back to the ancient Greeks, and is reflected by the Greek aphorism "know Thyself" (as cited in, Luthans & Avolio, 2003). Various definitions of authentic leadership have been developed over the years. Some of the first uses of authenticity related to leadership emerged within sociology and education (Hannah & Chan, 2004). Although in 1960, Seeman described inauthenticity as an excessive plasticity of the leader, seeking to comply with perceived demands from public roles, subsequent researchers defined authentic leadership slightly differently. For example, Luthans and Avolio (2003) defined authentic leadership as being

> "…a process that draws from both positive psychological capacities and a highly developed organizational context, which results in both greater self-awareness and self-regulated positive behaviours on the part of leaders and associates, fostering positive self-development" (p.243).

Authentic leaders are deeply aware of how they think and behave and are perceived by others as being aware of their own and others values/moral perspectives, knowledge, and strengths (Avolio et al., 2004). They are aware of the context in which they work, and are confident, hopeful, optimistic, resilient, and of high moral character. Authentic leaders are guided by a set of ultimate values that represent an orientation toward doing what is right for those on their team (Avolio et al., 2004). Shamir and Eilam (2005) defined authentic leaders as being true to themselves, rather than faking their leadership; authentic leaders are motivated by personal convictions, rather than the attainment of statues, or other personal benefits; authentic leaders are originals, not copies; and the actions of authentic leaders are based on personal values. However, one of the most widely used models of authenticity is defined in Gardner, and associates' (2005) model of authentic leadership.

Gardner, Avolio, Luthans, May, and Walumbwa (2005) proposed a self-based model, which sums up the definition of authentic leadership and focuses on the development of authentic leaders

and authentic followers and ultimately makes authenticity something that can be developed in leaders (Avolio & Luthans, 2006; Luthans & Avolio, 2003). In other words, authentic leaders that role model authentic leadership, encourage development of authenticity in others as well. The Gardner, et al. (2005) model highlights core self-awareness, balanced processing, relational transparency, and ethical/moral, characteristics of the authentic leader.

1) **Relational transparency**, means being open with others, sharing one's true thoughts and feelings, and encouraging others to share ideas.
2) **Ethical/moral** perspective is defined as self-regulation guided by internal moral standards and values resulting in behaviors and decisions consistent with those values. Furthermore, ethical/moral behaviors provide evidence that decision making is consistent with internalized values.
3) **Balanced processing** is defined as behaviors of leaders who gather and analyze all relevant data and viewpoints, both positive and negative before making decisions.
4) **Self-awareness** refers to acknowledging one's own strengths and weaknesses and understanding how they affect others.

Furthermore, authentic leaders are deeply aware of how they think and behave, and are perceived by others as being aware of their own and others perspectives (Avolio et al., 2004). Gaining insight into the self through exposure to others, and being aware of one's impact on other people.

Although transformational and authentic leadership have many similar characteristics, there are some unique differences. Transformational leadership revolves around the process of changing and transforming people, where as authentic leaders are anchored by their own deep sense of self (i.e., self-awareness). Thus, authentic leaders know themselves and remain true to their values and they choose leadership roles that are consistent with internal self-concepts and goals, and less focused

on change. Moreover, the outcomes for the two types of leaders may differ, as transformational leaders often try to develop followers into leaders (Avolio, 1999; Bass, 1985), whereas authentic leaders focus on follower development toward achieving authenticity, which may not involve serving in a leadership role.

Authentic leaders build enduring relationships and lead with purpose, meaning, and value; interestingly, they may not be described as charismatic or inspirational by others (Avolio & Gardner, 2005; George, 2003). Authentic leadership focuses less on inspirational appeals, dramatic presentation or other forms of impression management, and more on their character; whereas transformational leaders have been shown to transform others and organizations through a positive vision. In other words, transformational leaders attempt to change followers for what they believe is for the common good; however, many people may not want to be in a leadership role, and thus, may feel forced into something that is not genuine or authentic to the person. There is growing evidence that authentic leadership is most desirable and effective for leading human beings and achieving positive outcomes in organizations (George et al., 2007; George, 2003; Walumbwa et al., 2008). When organizational leaders act upon their true values, beliefs, and strengths to help followers, there is a higher level of employee well-being, which in turn positively impacts follower performance (Ryan & Deci, 2001; Walumbwa et al., 2008).

In summary, different leadership styles were explored and defined based on previous research. Although transformational leadership has become the most widely used and embraced leadership style of nurse leaders, it does not explain the increase in bullying behaviors in nursing. Therefore, it is time to explore a new style of leadership; authentic leadership highlights the importance of self-awareness and being genuinely true to yourself and your followers. Therefore, authentic leadership was explored in the current study.

Summary

In summary of this chapter, job satisfaction is described as an attitude that has affective, cognitive, and behavioral components. Problems defining job satisfaction can be related to differences in individual perception. Furthermore, job satisfaction can be described from a global perceptive or facet perspective. Since the goal of this study was to measure overall job satisfaction, a global perspective was most appropriate. Although there are many job satisfaction theories, the OFNPR was selected to guide this thesis study. The OFNPR was chosen because it revolves around the phenomenon that organizational factors and person factors contribute to job satisfaction. Workplace bullying has been defined and explored, with key components including: occurring repeatedly and regularly (e.g. weekly) and over a period of time (e.g. about six months). Furthermore, workplace bullying is escalating in nursing, even though managers have embraced a more transformational leadership style; thus, something is not working. Therefore, it is time to explore a new style of leadership to address workplace bullying. Authentic leadership is described as encompassing balanced processing, relational transparency, internalized moral perspective, and self-awareness (Avolio et al., 2007; Gardner, Avolio, Luthans et al., 2005; Walumbwa et al., 2008). Therefore, the thesis study explored the relationship between job satisfaction, bullying, and authentic leadership.

Definitions of Terms

1. **Job satisfaction**: Locke (1969) defined job satisfaction as a "pleasurable emotional state resulting from the appraisal of one's job as achieving or facilitating one's job values" (p.317).
2. **Bullying:** Einarsen et al. (2003) defined, bullying as:

> "… harassing, offending socially excluding someone or negatively affecting someone's work tasks. To be considered bullying, the behavior must occur repeatedly and regularly (e.g. weekly) and over a period of time (e.g. about six months). Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts" (p. 15).

3. **Authentic Leadership:** Luthans and Avolio (2003) define authentic leadership as

> "…a process that draws from both positive psychological capacities and a highly developed organizational context, which results in both greater self-awareness and self-regulated positive behaviours on the part of leaders and associates, fostering positive self-development" (p.243).

4. **Turnover**: nursing staff voluntarily leave or transfer from the primary employment positon. Voluntary termination excludes dismissals, leaves/absences due to medical/education reason and voluntary retirement (O'Brien Pallas et al., 2010). Although it is recognized that nurse turnover is a complex concept, and turnover has many components to it, however, for the purpose of this study, turnover is only defined briefly, as it is not a central concept.

CHAPTER III: REVIEW OF THE LITERATURE

Nursing research has demonstrated that job satisfaction is closely related to workplace factors that include bullying and the leadership styles of managers. The purpose of this chapter is to review the literature on job satisfaction, bullying, and authentic leadership in order to inform this research study. More specifically, the history of job satisfaction and its relationship to bullying on medical/surgical units will be explored. Furthermore, this chapter reviews the literature on leadership styles, including authentic leadership and its impact on nurse bullying and job satisfaction. Within the context of the OFPNR, bullying and authentic leadership can be considered to be organizational factors influencing job satisfaction; however, these two topics will be discussed separately because of their central role in this research study. In essence, by reviewing this literature, the goal is to identify the shortcomings in previous studies on these topics and to establish rationale for adding to existing knowledge of nurse job satisfaction, bullying, and authentic leadership in the current study.

Search engines that were used included PubMed, Cochrane Library, Scopus, CINAHL, Education: A SAGE full-text collection, PSYCarticles, Psychology: A SAGE full-text collection, Psychiatry online, Psycinfo, Social science full text, Sociology: A SAGE full-text collection, websites of relevant associations, and Google. Search terms that were used included: job satisfaction, nurse job satisfaction, leadership, authentic leadership, bullying, medical-surgical nursing units, as well as a combination of text words such as, nurse job satisfaction OR bullying, nurse job satisfaction OR medical/surgical units, nurse bullying, leadership OR nurse job satisfaction, leadership OR bullying. Furthermore, the snowball technique was used to broaden searches and searches were limited to English publications.

Job Satisfaction

Historically, research in the area of job satisfaction emerged in management with Frederick Winslow Taylor contributing significantly to the development of this concept; his book entitled: "Principles of Scientific Management," was published in 1911. Taylor wrote about the shift from skilled labor towards hourly wages. The initial use of Taylor's scientific management principles by organizations increased productivity because workers had to work at a faster pace, but workers became exhausted and dissatisfied with this approach, which prompted the Hawthorne studies. The Hawthorne studies were among the most significant precursors to the study of job satisfaction. These studies, primarily lead by Elton Mayo of Harvard Business School focused on the effects of various conditions on workers' productivity. The results of these studies demonstrated that changes in work conditions could increase productivity (i.e. the Hawthorne Effect). In summary, the seminal Hawthorne studies indicated that there were other factors influencing job satisfaction besides pay; working conditions also influence an employee's job satisfaction. Research in the area of job satisfaction continued to develop more fully during the early1950s, when job satisfaction was explored in terms of the specific attitude of what makes a happy worker because a happy employee is a more productive worker (Wright, 2006).

Interestingly, although job satisfaction has been studied in many sectors including psychology, sociology, and management, prior to the 1970s, nursing studies relied on the theoretical fields of psychology and management to inform understandings of job satisfaction (Chen-Chung, et al., 2003). Nurses did not start exploring job satisfaction, and begin developing their own theoretical frameworks for job satisfaction until the nursing shortages of the 1970s. One notable exception was Nahm (1948) who published one of the first nursing satisfaction studies in1948. Nahm examined nurse satisfaction and the environment in a school of nursing. The study's objective was to observe if the enthusiasm and high motivation of a student can be preserved over time and if dissatisfaction after graduation can be reduced (Nahm, 1948). Nahm found that a nurse's job satisfaction decreased

significantly after graduation. Likewise, the problem still exists today with newly graduated nurses having one of the highest levels of turnover, which is arguably an indicator of job dissatisfaction among nurses.

Nurse researchers began to take notice of job satisfaction during the nursing crisis in the 1970s (Chen-Chung, et al., 2003). The nursing shortage was fuelled by dissatisfaction with working conditions (Alspach, 2000). During this time, organizations faced high attrition rates and found it difficult to recruit and retain qualified nurses. Nurses moved around to find workplaces that offered less stressful working conditions, manageable workloads, and overall more attractive environments.

In essence, the importance of job satisfaction came to the fore in nursing when the balance between supply and demand was unequal. During this time, nurse leaders and managers noticed that some hospitals were better able to recruit and retain staff than other hospitals (Kelly et al., 2011). Research indicated that these "magnet" hospitals had common organizational characteristics that were associated with higher levels of nurse satisfaction and retention (Kelly et al., 2011; Kramer & Hafner, 1989). Magnet hospitals consistently demonstrated higher quality nurse work environments, better patient outcomes, and higher levels of job satisfaction (Armstrong et al., 2009; Shields & Ward, 2001). Additionally, further research verified that key factors in the work environment influenced job satisfaction (Kramer & Schmalenber, 1991). These findings, in turn, established the foundation for further investigations on the relationship between job satisfaction and the nursing environment.

Subsequent nursing researchers began to explore the relationship between job satisfaction and intent to leave (Abualbub & Alghamdi, 2012; McCarthy et al., 2007; Simpson, 2009). A consistent theme throughout the nursing literature was that job satisfaction is a significant contributor to intent to stay in current position (Abualbub & Alghamdi, 2012; Borda & Norman, 1997; Boyle et al., 1999;

Davidson, 1997; Dockery, 2004; Francis-Felsen et al., 1996; Gurney et al., 1997; Hinshaw et al., 1986; Larrabee et al., 2003; Lucas et al., 1993; Lu et al., 2005; Lum et al., 1998; McCarthy et al., 2007; Rambur et al., 2003; Sabiston & Laschinger, 1995; Shields & Ward, 2001). For example in a cross-sectional study of registered nurses' (RNs) in the Republic of Ireland (N=352) "intent to stay or leave," McCarthy et al. (2007) found that job satisfaction was the most accurate predictor of intent to stay in one's current position, ($p < .0001$). Moreover, 47% of medical/surgical nurses planned to leave, while only 18% of critical care nurses planned to leave their units. Similarly, in a large British cross-sectional survey study (N=9625) that examined nurse retention and the impact of job satisfaction, Shields and Ward (2001) found that nurses who reported overall dissatisfaction with their jobs had a 65% higher probability of intent to quit than those nurses who reported been satisfied. Likewise, nurses working in medical/surgical areas and midwifery had a higher probability of intending to quit than those in specialized areas (Shields & Ward, 2001). Thus, the evidence suggests that job satisfaction is a crucial component in retention, particularly for nurses working in medical/surgical areas.

The literature also reveals that units that have higher nursing job satisfaction have higher quality patient and organizational outcomes (Best & Thurston, 2004; Brown & Perterson, 1993; Davidson et., 1997; Chen-Chung, et al., 2003; Tzeng, 2002). Outcomes include higher levels of organizational commitment (Boyle et al., 1999; Brown & Perterson, 1993; Taunton et al., 1997), higher levels of quality patient care (Leiter et al., 1998; Tzeng et al., 2001; Tzeng et al., 2002), less burnout (Abbott et al., 1994; Armstrong-Stassen et al., 1994; Clarke et al., 2002; Tzeng, 2002), and lower mortality rates (Aiken et al, 1994; Aiken et al., 2000; Al-Haider & Wan, 1991). In a large nursing study in the United States (US; N=1205) that examined patient outcomes in magnet and non-magnet hospitals, Aiken et al. (2000) found that positive organizational climate, specifically organizational support (e.g. nursing management) for nursing care, is an undervalued determinant of

poor patient outcomes and nurse recruitment and retention failure. Thus, based on the evidence, researchers have concluded that organizational support, such as management, is an essential component to healthcare outcomes, including nurse job satisfaction.

The following review of the job satisfaction literature has been organized within the context of the OFPNR. Thus, research evidence related to job satisfaction will be discussed within the context of influencing factors, to include person factors (i.e. demographics) and organizational factors (nurse/MD and nurse/nurse collaboration, nursing management, professional practice, staffing and resources, positive scheduling climate and nursing competence).

Person Factors

This section specifically focuses on person or demographic factors. In particular, the demographic characteristics of age, years of experience, education, gender, and area of employment was explored.

Age. Although the research evidence is somewhat mixed**,** a consistent theme throughout the nursing literature is that job satisfaction increases linearly with age, in other words, the older the nurse, the greater their level of job satisfaction (Blythe et al., 2002; Boyle et al., 2012; De Gieter et al., 2011; Gurkova et al., 2012; Ingersoll et al., 2002; Lee & Wilbur, 1985; Price & Mueller, 1981; Rhodes, 1983; Shields & Wards, 2001; Taunton et al., 1997). In a cross sectional survey in the US; (N=1853) that explored nurses' job satisfaction and commitment to the organization, Ingersoll et al. (2002) found that older nurses (i.e. older than 50 years), were significantly more satisfied than nurses younger than 50 years old ($p<.0001$). Gurkova et al. (2012) found that not only age ($p<0.01$), but also years of experience ($p<0.05$), were significantly related to job satisfaction. Moreover, Song et al. (1997) found that age and years of experience were highly intercorrelated ($p<.05$). Interestingly, Strordeur et al. (2006) found that in "attractive hospitals" (i.e. successful in nurse recruitment and

retention), nurses were older and had higher institutional seniority ($p<0.001$). Strordeur et al. drew the conclusion that older nurses created a more stable environment and had stronger bonds for attachment, which could be forfeited if nurses were to leave their hospital.

Specific to Canadian nurses, in a mixed-methodology study (N=1396) that explored whether nurses of different ages had different attitudes toward their work, Blythe et al. (2002) found that nurses 50+ were significantly more satisfied with their pay than nurses 20-29 ($p<.05$). Moreover, nurses 50+ were significantly more satisfied with their promotion opportunities than those who were 30-39 ($p<.05$). Additionally, the oldest nurses had greater intrinsic job satisfaction than nurses 30-39 ($p<.05$) and were significantly more satisfied with type of work, financial rewards, and communication within the organization. Although their outcomes were somewhat similar to previous results, Blythe et al. (2002) drew the unique conclusion that perhaps older nurses were more satisfied because of their acquired seniority in a unionized workforce, which protected them from the career disruption that was experienced by younger nurses. Additionally, union regulations ensure that nurses with the most seniority have preferred access to full time jobs or better shifts. On the other hand, Blythe et al. (2002) found that nurses 30-39 are the least committed and least satisfied of all the nurse groups, most likely because of non-work priorities, such as domestic responsibilities, including having young children at home. The youngest nurses 20-29 reported greater satisfaction with opportunities for promotion than nurses in the 30-39 age group; however, the youngest nurses reported higher levels of stress with more emotional exhaustion than the oldest group. Blythe and colleagues drew the conclusion that young nurses received insufficient mentoring and were unprepared for the responsibility of nursing.

In direct contrast, several studies have reported that younger nurses are more satisfied than older nurses (Giallonardo et al., 2010; Kovner et al., 2009; Laschinger, 2012; Wilkins & Shields, 2009). In a large cross-sectional study of Canadian nurses (N=18,676), Wilkins and Shields (2009)

found that nurses aged 45 or older were significantly more dissatisfied compared with those aged 25 to 34. Laschinger (2012) reported that most new graduate nurses worked on medical-surgical units (53%) and most (80%) were satisfied with their jobs (Laschinger, 2012). Laschinger also found that organizational supports were significantly related to job satisfaction, and that most graduates were satisfied: however, she also concluded that more work should be done to improve new graduate work environments for retention based strategies used by management to address the nursing shortage.

Other researchers have found that age has no influence on job satisfaction (Blegen, 1993; Luthans & Thomas, 1989; Ma et al., 2003). In a cross-sectional study (N=3472), Ma et al. (2003) found no statistically significant relationship between age and job satisfaction. Likewise, Blegen (1993) found age to have very weak correlations to job satisfaction. Rationale for different findings throughout the literature may be related to nurses from different generations having different work related values and needs, and these differences need to be taken into account (Takase et al., 2009). Interestingly, Takase et al. acknowledged that nurses born after 1975 had a lack of motivation in the workplace. Takase et al. drew the conclusion that this could be from their lack of confidence, which may be related to the transitional period from traditional clinically orientated style of education to more of an academic education. This transition is related to the struggle to establish nursing as an academic discipline rather than an occupation. Therefore, more research is needed to verify relationships between age and job satisfaction.

Years of experience. As years of experience are generally associated with age, it is not surprising that the majority of the literature reports that job satisfaction is positively related to experience (Gurkova et al., 2012; Kaitelidou et al., 2012; Kalisch et al., 2010; Li & Lambert, 2008; Pillay, 2009; Rosenthal et al., 1989; Song et al., 1997). In a cross-sectional study (N=1055) of medical/surgical, emergency, intensive care, outpatient units, operating rooms and geriatrics nurses, Gurkova et al. (2012) found that years of nursing experience were positively related to job

satisfaction ($p<0.01$). Based on their findings, Li and Lambert (2008) concluded that the rationale for increased job satisfaction with experience may be related to the increasing salary with years of experience. As well, some researchers have concluded that the rationale for lower job satisfaction among less experienced nurses may be associated with new graduates' experiences of negative workgroup interactions, because of their reports of high levels of incivility (Boychuck & Duchscher, 2008; Cho et al., 2006; Laschinger et al., 2009c; Porath & Pearson, 2010). Interestingly, medical-surgical areas have the highest numbers of novice nurses compared to any other clinical setting (i.e. < 5 years of experience; Canadian Institute for Health Information, 2007). Thus, more research should be focused on medical-surgical nurses.

Interestingly, Gurkova et al. (2012) also found that nurses with the least amount of work experience (i.e. < 5 years) and most experience (i.e. > 26 years) were considering leaving the workplace. Gurkovea et al. (2012) concluded that the nurses with the most experience may have a loss of interest in professional activity, reduced tolerance to stress and tension, feelings of loss of different competencies, and personal problems (Gurkova, et al., 2012).

Several researchers found no statistically significant relationship between years of experience and job satisfaction (Irvine & Evans, 1995; Ma et al., 2003; McDonald et al., 2012; O'Brien-Pallas et al., 2010; Price & Mueller, 1981). In a cross-sectional study (N=3472), Ma et al. (2003) found no statistically significant difference between years of experience and job satisfaction. While McDonald et al. (2012) found similar results their sample was relatively small (N=72) and only included NICU nurses. Therefore, further research should investigate the relationship between years of experience and job satisfaction.

Education. Although, outcomes relating to education and job satisfaction tend to be controversial, several studies have reported statistically significant findings that higher levels of

education are associated with increased job satisfaction (Ingersoll et al., 2002; Juntao et al., 2006; Lu et al., 2007; Ning et al., 2009; Rambur et al., 2005). Ingersoll et al. (2002) reported that educational background was significantly associated with job satisfaction ($p<.0001$); specifically, masters prepared nurses were significantly more satisfied than baccalaureate nurses. Additionally, Ingersoll et al. also found that the highest level of job satisfaction was reported by educators, followed by advanced practice nurses, and that staff nurses were the least satisfied. Rambur et al. (2005) conveyed that more educated nurses not only reported higher job satisfaction, but also lower levels of stress ($p<.0002$). Rambur et al. concluded that additional education gives nurses the opportunity to obtain positions with less stress and more security.

On the other hand, there was limited data on job satisfaction been inversely related to education (Blegen, 1993; Shields & Wards, 2001). Blegen found an inverse relationship; however, the relationship was weak and he had a vague description of how education was measured. The notable exception was in a large British study (N=9625) that examined the attitudes of medical/surgical, community, mental illness, geriatric, midwifery, and, paediatric nurses (Shields &Ward, 2001). Shields and Ward reported that less educated enrolled nurses in their study were more satisfied than registered nurses. According to Shields and Ward, a reason for less educated nurses being more satisfied than higher educated nurses could be associated with lower expectations in terms of pay and promotion based on their constrained promotion prospects. However, Shields and Ward only compared enrolled nurse and registered nurses in their study.

The majority of research indicates that there is no statistically significant relationship between educational level and job satisfaction (Blegen & Mueller, 1987; Eberhardt et al., 1995; Genrich, 1990; Ingram, et al., 1994; Kovner et al., 2006; McDonald et al., 2012; O'Brien-Pallas et al., 2010; Robinson et al., 2006). For example, Kovner et al. found no statistically significant results of nursing

educational levels, between diploma, associate, baccalaureate, master's/doctorate levels and job satisfaction.

Gender. Nursing research consistently reports that female nurses are more satisfied than male nurses (Bartol & Wortmann, 1975; Clark, 1996; Kalisch et al., 2010; Kovner et al., 2009; Murray & Atkinson, 1981; Shields & Ward, 2001; Wharton et al., 2000). Kovner et al. (2009) found that being female increased the probability of being satisfied compared to males ($p<0.012$). Kalisch et al. (2010) found similar results that being female increased job satisfaction significantly ($p<0.001$). Some non-nursing research has also found that men in the workplace are more satisfied than women (Forgionne & Peeters, 1982; Hulin & Smith, 1964; Weaver, 1974); for example, Forgionne and Peeters (1982) found that male managers were more satisfied than female managers in organizations. However, this study involved non-nursing managers.

Several studies report that there are no significant differences between the sexes in relation to job satisfaction in nursing (Brief et al., 1977; Eskildsen et al., 2003; Golembiewski, 1977; Kovner et al., 2006; Smith & Plant, 1982; Weaver, 1978; Wilkins & Shields, 2009). For example, in a large Canadian survey (N=18,676) that examined job dissatisfaction among nurses, Wilkins & Shields (2009) found no significant differences between job satisfaction of males and females. Nonetheless, the majority of literature supports the notion that female nurses are more satisfied than their male counterparts. Kalisch et al. suggested that men may be less satisfied with the nursing profession because they are the minority within the field. Also, men may identify more with the male dominated physician profession, and thus, become dissatisfied with nursing's lower status.

Area of employment/practice. Sociological research indicates that unit types differ in multidisciplinary team relations (Adams &Bond, 1997). Although most research on job satisfaction ignores unit type or fails to control for unit type (Boyle, et al., 2006), there is evidence to suggest that there are significant differences in nurse job satisfaction between different units.

The literature consistently reports that nurses on medical-surgical, or combined medical-surgical units have lower job satisfaction than nurses in other areas (Gowell & Boverie, 1992; Ingersoll et al., 2002; Kalisch et al., 2010; Shields & Wards, 2001; Wakefield et al., 1988). For example, Ingersoll et al. (2002) found that nurses who worked in medical-surgical, critical care, and rehabilitation units were significantly less satisfied than other areas, such as maternal child ($p<.0001$). Furthermore, in a cross-sectional nursing study in the US (N=3,675), Kalisch et al. (2010) found that emergency department nurses were not only significantly more satisfied than medical-surgical nurses ($p<0.05$), but also had higher satisfaction with teamwork and collaboration ($p<0.01$). Kalisch et al. concluded that emergency department nurses are more satisfied because they work more as a team. Moreover, Kalisch et al. suggests strategies to develop successful team building should include effective leadership. Therefore, more research needs to focus on teams and leadership.

On the contrary, Boyle et al. (2006) found that medical-surgical nurses ranked more moderately regarding job satisfaction in their study, and emergency department nurses were the least satisfied. Boyle et al. (2006) concluded that their disparate findings may have been related to their use of a broader range of comparison unit types and they measured more specific domains of job satisfaction. Boyle et al. (2006) noted that medical-surgical nurses were among the youngest in age and lowest in average years in practice. Additionally, Boyle et al. suggested that having more advanced practice nurses available would improve the work environment. Interestingly, when work satisfaction was broken into different domains, Boyle et al. found that medical-surgical nurses were more dissatisfied with nurse-to-nurse interactions than any other units. Wakefield et al. (1988) found that emergency units had significantly higher satisfaction than medical-surgical and orthopedic units. Wakefield et al. concluded that satisfaction was greater on labor-intensive units; additionally, Wakefield et al suggested that future research should evaluate why emerging data supports the notion that ICU units are more stressful, as their findings demonstrate this to be untrue.

Although there is somewhat conflicting evidence as to which types of units are associated with the least satisfied nurses, many studies fail to even identify what specific unit type they are addressing. This is a significant gap in the research literature because the majority of hospital nurses are medical-surgical nurses (Gowell & Boverie, 1992; Ingersoll et al., 2002; Shields & Wards, 2001; Wakefield et al., 1988). Therefore, more research emphasis must be focused on medical-surgical units and staff job satisfaction.

There are also mixed results relating to urban and rural job satisfaction. Mills and Blaesing (2000) found that urban nurses were more satisfied with nursing than rural nurses. However, Baernholdt and Mark (2009) found that rural nurses were more satisfied. Baernholdt and Mark reported that this was because of smaller units, less complex patients, and lower vacancy rates in rural hospitals.

In summary, the nursing literature has historically been inconsistent related to the relationship between the person factors of age, years of experience, education, gender, education, area of employment, and job satisfaction. Furthermore, existing evidence suggests that medical-surgical units have high rates of job dissatisfaction; however, there is minimal research specifically associated with medical-surgical units, and nurse job satisfaction. Further research relating to person factors and job satisfaction in medical surgical nurses is clearly justified, based on this review of the literature.

Organizational Factors

Although both person factors and organizational factors are crucial to job satisfaction some studies suggest that person factors have less influence on job satisfaction than the work environment or organizational factors (Irvine &Evans, 1995; Lewis, 2006). Using the OFPNR as a guide, this section will review the literature of organizational factors, including: nurse/physician and nurse/nurse

collaboration, nursing management, professional practice, staffing and resources, positive scheduling climate and nursing competence.

Nurse/nurse and MD/nurse collaboration. Collaboration can be described as interactions between nurses and between nurses and physicians that enable the knowledge of both professions to influence patient care (Weiss & Davis, 1985). There is consistent evidence that positive work relationships are associated with a higher level of job satisfaction (Adams & Bond, 2000; Aiken et al., 2001; Ames et al., 1992; Gifford et al., 2002; Janssen et al., 1999; Lee, 1998; McDonald et al., 2012; Nelson et al., 2008; Price & Mueller, 1981; Rafferty et al., 2001; Rosenstein, 2002; Simons, 2008; Wilkins & Shields, 2009). Collaboration between the multi-disciplinary team is essential for fostering healthy work environments. Collaboration not only benefits patients but also influences satisfaction among healthcare workers. However, poor working relationships can be harmful to patient care and can result in medical errors and other negative outcomes (Estabrooks et al., 2005; Espin & Lingard, 2001; Hickson & Entman, 2008).

Specific to physician/nurse relationships, Nelson et al. (2008) found that strong nurse-physician relationships improved quality patient care and fostered job satisfaction for both nurses and physicians. Furthermore, Chang et al. (2009) found that physicians were the most satisfied with their jobs compared to nurses and other healthcare professionals ($p<0.05$). However, Chang et al. also found that nurses had higher scores for perceived collaborative relationships than physicians ($p<0.05$). Interestingly, among the physicians, perception of quality of patient care and collaborative relationships were the best predictors of job satisfaction ($p<0.05$); however, among nurses, perception of quality of patient care and collaborative relationships, but also age, and number of children were statistically significant predictors of job satisfaction. Chang et al. concluded that physician's higher satisfaction is associated with higher yearly salaries. This contention has been supported by other researchers; for example, Yaktin et al. (2003) reported that nurses were most dissatisfied with pay

and advancement. Chang et al. also concluded that physicians had the lowest scores for collaborative relationships because physicians are generally decision-makers, and primarily in dominant roles in Japan, and therefore may have a different perspective of collaboration than nurses.

Wanzer et al. (2009) reported that communication between physician and nurse was a significant factor of job satisfaction ($p<.002$) and relationship satisfaction ($p<.001$). More specifically, nurses' job satisfaction was significantly influenced by physicians' communication that unleashed the use of immediacy, listening, and empathy ($p<.001$). Wanzer et al. concluded that the more physicians increased their communication with nurses, the more likely nurses were to report positive relationships with physicians and higher job satisfaction. Interestingly, empathy was the only significant predictor for nurses' reports of relationship satisfaction and collaboration. Wanzer et al. concluded that it is important to let nurses express their concerns, as they then feel that their opinions are more valued and this would increase their job satisfaction. Finally, Rafferty et al. (2001) found that nurses who had higher scores on interdisciplinary teamwork were significantly more satisfied with their jobs, were less likely to quit, and had lower burn out scores.

Although conflict among healthcare professionals is prevalent, lack of nurse to nurse collaboration is a recently recognized and escalating problem that is commonly witnessed in nursing. In a cross-sectional study (N=834), Adam and Bond (2000) found a significant relationship between job satisfaction and cohesion of the ward nursing team ($p<0.001$). A common theme throughout the nursing literature is that nurses on medical-surgical units experience less group cohesion and collaboration than other units (Kalisch et al., 2010; Lucas et al., 1993; Nelson et al., 2008; Shields & Ward, 2001). Kalisch et al. (2010) found that units with higher levels of teamwork had statistically significant greater job satisfaction ($p<0.001$). Kalisch et al. (2010) found that nurses in emergency departments had higher satisfaction with teamwork than medical-surgical nurses ($p<.01$); nonetheless, a major gap in the literature is that most research in healthcare on teamwork and

collaboration has focused on high-risk areas such as perioperative, critical care, and emergency settings (Mills et al., 2008; Salas et al., 2007; Silen-Lipponen et al., 2005) and few studies have specifically focused on nurse to nurse collaboration on medical-surgical units.

Overall, most studies support the argument that collaboration, and teamwork are major organizational contributors to job satisfaction; however, few studies have specifically focused on medical-surgical units.

Nursing Management. Numerous studies have found that nurse managers are among the most significant influencing factors on staff job satisfaction in the nursing work environment (Chu et al., 2003; Cohen et al., 2009; Duffield et al., 2010; Kovner et al., 2006; McGurie & Kennerly, 2006; Sawatzky & Enns, 2012). More specifically, effective leadership in managers can lead to higher levels of staff satisfaction. The literature consistently reports a positive relationship between job satisfaction and nursing management (Duffield et al., 2010; Gunnarsdottir et al., 2009; Sawatzky & Enns, 2012; Sellgren et al., 2008).

Certain managerial traits are attributed to nurse managers who positively influence staff nurse job satisfaction. In a cross-sectional study (N=695) Gunnarsdottir et al. (2009) found that unit level support, which included managers who were supportive of their staff, used praise and recognition for a job well done, were good managers and leaders, backed up nurses in decision making, were supportive of new and innovative ideas about patient care, offered flexible shift patterns, and who were active in staff development education, was significantly related to job satisfaction ($p<0.001$). This finding is consistent with other researchers as well (Aiken et al., 2002; McNeese-Smith, 1999; Upenieks, 2002). Gunnarsdottir et al. concluded that supportive and empowering relations with front-line managers lead nurses to have positive attitudes and may enhance their ability to provide higher level quality patient care. However, Gunnarsdottir et al. also noted that the exact role of front-line managers and methods for supporting nurses are not clear and need further investigation.

Duffield et al. (2010) reported similar results. In a large cross-sectional study in Australia (N=2488), Duffield et al. found that nurse managers who are perceived as a good leaders by their nursing staff, were visible, consulted with staff, and provided praise and recognition. On the other hand, lack of recognition was associated with poor morale, and reduced productivity, and was the primary reason for turnover among employees (Duffield, et al., 2010). Many researchers have reported that staff perception of ideal leadership is about being fair, respectful, and supportive (Duffield et al., 2010; Ellenbecker et al., 2007; Gess et al., 2008; Tang, 2003); this notion is consistent with Avolio et al.'s (2004) authentic leadership model. (see Chapter 2)

Specific to medical-surgical nursing, Boyle et al. (2006) found that satisfaction with nursing management on medical-surgical units scored moderately compared to other units, which is contrary to previous literature (Ingersoll et al., 2002; Wakefield et al., 1988). Boyle et al. noted that these differences may be related to variation in samples and definition of unit types, methodological issues, and different instruments used. Furthermore, Boyle et al. concluded that further investigation should focus on specific aspects of the work environment for specific units, for example nursing management.

Overall, nursing management is a central component to nurses' job satisfaction. Staff nurses desire a manager who is supportive towards new ideas, supportive to pursue further education, who is a good manager and leader, who backs up nursing staff in decision making, consults with staff, also who praises and recognizes a job well done. Furthermore, research has demonstrated that further investigations of specific aspects of the nurse's work environment, like management should be researched in order to improve quality patient care.

Professional practice in nursing is defined "…as a system (structure, process, and values) that supports registered nurse control over the delivery of nursing care and the environment in which care is delivered "(Hoffart & Woods, 1996, p.354). According to Choi's et al. (2004) PNWE

instrument, professional practice involves opportunities for career advancements, participation in policy decisions, opportunities to serve on hospital committees, involvement in internal governance of the unit, support for new ideas about patient care, and support for further education. Furthermore, professional practice involves administration listening to concerns, continuing education opportunities, contributions that are publicly acknowledged, quality assurance programs, having clinical nurse specialist available to provide patient care consults, and having a chief executive nursing officer who has equal power and authority to other top hospital executives.

Numerous studies link the factors of professional practice environments to nurse outcomes, such as job satisfaction (Aiken et al., 2001, 2002, 2008; Havens & Aiken, 1999; Mark et al., 2003). Havens and Aiken (1999) reported that nurses' job satisfaction is significantly higher in hospitals that enact professional nursing practice. Similarly, Patrician et al. (2010) found that unfavourable professional practice environments were significantly related to job dissatisfaction. Choi et al. (2004) found that nurses in magnet hospitals rated professional practice significantly higher ($p<.05$) than nurses in non-magnet hospitals. Moreover, less emotional exhaustion and safer work environments are reported in hospitals that engage in professional nursing practice (Institute of Medicine, 1983).

Specific to medical-surgical nursing, Mark et al. (2003) found that professional nursing practice had a strong positive impact on work satisfaction and was associated with lower nursing turnover. Additionally, Mark et al. found that professional nursing practice was enhanced by the availability of support services and was decreased on larger nursing units. Mark et al. concluded that the rationale for lower satisfaction with professional practice on larger units may be related to better communication structures on smaller units.

Numerous studies report that nurses who have opportunities for growth are more satisfied (Kovner et al., 2009; Laschinger et al., 2003; Ulrich et al., 2005; Upenieks, 2003). In a large cross-

sectional study (N=3500), Ulrich et al. (2005) found that nurses who were dissatisfied in their current job reported much fewer growth opportunities. Only 26% rated their opportunities as excellent or very good 32% rated them as good, and 40% rated their opportunities as fair or poor. Ulrich et al. also noted that the majority of nurses do not feel they have adequate opportunities to influence decisions about the workplace organization.

Laschinger et al. (2003) found that characteristics of magnet hospital including: access to opportunity, information, support, resources, total empowerment, formal power, informal power, and global empowerment were significant predictors of job satisfaction ($p<.0001$). Interestingly, Laschinger et al. also found that nurses who worked in more specialized areas, were more likely to experience positive working conditions. For example, nurses who worked in maternal-child areas had significantly higher satisfaction scores than those who worked on general medical-surgical units. Laschinger et al. concluded that work environments that provide access to information, support, and resources and opportunities to learn and grow, as well as flexible job activities and strong alliances, can create work settings that support professional practice.

In conclusion, there is fairly consistent evidence that professional practice is significantly related to nurses' job satisfaction. Research to date supports the argument that opportunities to learn and grow within the work environment are essential components of professional practice. However, there is minimal research that has explored professional practice in medical-surgical nurses.

Control/autonomy can be described as opportunities for career advancements, autonomy in clinical decision making, participating in organizational decision making, control over work and work settings, and the amount of responsibility one has in the workplace. Autonomy refers to the degree to which nurses have the freedom to act on what they know (Aiken et al., 1997). Although professional practice and control/autonomy have similar components, control/autonomy is described

slightly differently from Choi's et al. (2004) description of professional practice. Thus, control/autonomy is more about the amount of individual control and responsibility and professional practice is about opportunities to grow and learn.

Research supports that nurses who perceive more control over their work (Cavanagh, 1992; Laschinger & Havens, 1996; McGilton & Pringle, 1999; Spector, 1986) and participate in decisions regarding their work environment (Dwyer et al., 1992; Prescott et al., 1987) report higher job satisfaction. In a nursing study (n=113), that explored how perceived and preferred clinical control and organizational control are associated with nurses' job satisfaction in long-term care settings. McGilton and Pringle (1999) found that nurses who perceived that they had more control in their organizational environment, such as control over decision making in developing procedures and scheduling of their work schedules were more satisfied. McGilton and Pringle concluded that the perception of personal control is essential to one's well-being and competence. Interestingly, it is important to note that although the majority of nurses preferred more control, some nurses wanted less control. McGilton and Pringle thought this may be related to nurse characteristics or their education and clinical specialities.

A common theme throughout the nursing literature is that shared decision-making has a significant effect on nurses' job satisfaction (Di Meglio et al., 2005; Kramer & Schmalenber, 2004; Leveck and Jones, 1996; Upenieks, 2003). Lack of involvement in decision making is a major source of nurse job dissatisfaction (Kramer & Schmalenberg, 2003). Leveck and Jones (1996) found that nurses who felt part of a valued team, participated in leadership activities, had greater unit cohesion and participative management were more likely to have higher job satisfaction and less likely to leave organizations.

Zangaro and Soeken (2007) also found that job satisfaction was significantly related to autonomy ($p<.05$). Furthermore, Zangaro and Soeken concluded that autonomy in nursing is

developed through years of experience and strong leadership. Moreover, Kovner et al. (2009) found that nurses who reported more autonomy and promotional opportunities were more likely to stay in their positions.

In a nursing study (N=305), that explored differences in job satisfaction among magnet and non-magnet hospitals, Upenieks (2002) found a significant relationship between job satisfaction and autonomy. Upenieks concluded that differences in job satisfaction scores may be explained by the amount of support received by the nurse managers or supervisors in making autonomous patient care decisions. Encouragement from management, let nurses in magnet environments more inclined to risk assuming responsibility for their practice. Upenieks also conclude that managers in non-magnet hospitals tend to employ a top-down style of management, leading to a less autonomous environment. Thus, overall, the literature supports that control/autonomy is a factor that is significantly related to job satisfaction.

Staffing and Resources encompasses staffing ratios/workload and rewards, such as pay/benefits**.** A consistent theme throughout the nursing literature is that nurses who work in areas with inadequate staffing and limited resources are less satisfied (Aiken et al., 2002; Bakker et al., 2010; Barrett & Yates, 2002; Chen et al., 2008; Davidson et al., 1997; Kovner et al., 2009; Lin et al., 2013; Strachota, et al., 2003; Shields, & Wilkins, 2009). When resources are limited, organizations try to get more done with less; therefore, there is an increase in job demands. Consequently, high levels of job demands can increase stress (Barrett & Yates, 2002; Lucas et al., 1993), increase workloads (Barrett & Yates, 2002; Davidson et al., 1997; Strachota et al., 2003l; Tai et al., 1998), and increase job tension, which in turn can lead to nurse dissatisfaction (Tai et al., 1998). However, consequences of high nurse workloads not only affect nurse job satisfaction, but also have a negative impact on patient outcomes, such as higher rates of pneumonia (Cho et al., 2003), and nosocomial

infections (Needleman et al., 2002). In other words, there are many consequences of inadequate staffing and resources.

Nursing workloads can be affected by many factors including: nurse-to-patient ratio (Gagnon et al., 2006), patient turnover (Duffield et al., 2007), nurse skill mix (Duffield et al., 2009), patient length of stay and acuity (Birch et al., 2003), and staff shortages (Buerhaus, 1997). In a large Canadian study of direct care and long term care nurses (N=18676), Shields and Wilkins (2009) found that nurses with higher workloads/staffing or resource inadequacy were more likely to be dissatisfied. Furthermore, Chiang and Lin (2009) report that staffing and resource inadequacy are the least favourable factors in the practice environment. In another Canadian study, Gagnon et al. (2006) found that the main sources of nurse dissatisfaction were linked to organizational issues, such as: nurse-to-patient ratio, workload, technical equipment, and material resources, physical work environments, and relationships with support services.

Factors such as high patient-to-nurse ratios, and work overload result in job stress (Byers & Unruh, 2002; Kuo et al., 2010; Raikkonen et al., 2007). Staff stress is linked to decreased quality of patient care, as well as, negative outcomes for staff, such as job dissatisfaction (Cohen-Mansfield, 1995). Byers and Unruh (2002) found that within units with insufficient staffing levels, workload was perceived as high, and job satisfaction was low. A unique finding by Raikkonen et al., (2007) was that the nurses' perceptions of adequate staffing levels were significantly related to the nurse's own professional skills ($p<0.001$). Raikkonen et al. concluded that staff with sufficient time can produce better quality of care, which in turn leads to higher perceptions of their own professional skills.

Specific to medical-surgical units, several studies have reported that medical/surgical nurses experience higher job stress than other areas (Kalisch et al., 2010; Lucas et al., 1993; Wakefield et al.,

1988). Lucas et al. (1993) found that medical-surgical nurses experienced significantly more job stress than nurses on critical care units ($p<.0001$). Lucas et al. concluded that medical/surgical units have patients with more diagnoses per year, than those in specialty units; thus, contributing to the amount of workload of nurses. Kalisch et al. (2010) found that nurses on paediatric intensive units, psychiatric units, and emergency departments were more likely to have higher job satisfaction ($p<0.05$). Kalisch et al. concluded that nursing staff who cared for more patients reported a lower level of satisfaction ($p<0.05$) and that higher levels of staffing adequacy leads to greater job satisfaction. However, other studies found that critical care (Donchin & Seagull, 2002) and emergency departments (Adali & Priami, 2002; Potter, 2006) have high stress levels. Researchers conclude that ED are more stressful than other departments because ED must deal with many unpredictable challenges, including sudden death, violence, trauma, and overcrowding (Adali & Priami, 2002; Potter, 2006). Overall, research in this area is inconsistent and inconclusive.

Intrinsic and extrinsic job rewards are important for job satisfaction (Klein & Dixon, 2000). Intrinsic rewards, such as recognition and praise, and extrinsic rewards, such as bonuses or pay, can both affect a nurse's job satisfaction. For example, numerous studies have found that salaries play a key role in nurse's job satisfaction (Kovner et al., 2006; Lober & Savic, 2012; Shields & Ward, 2001).

However, there is some controversy over the variable of pay, as many nursing studies report that pay is not that important compared to other variables (Irvine & Evans, 1995; Lorber & Savic, 2012; Price & Mueller, 1981). A unique finding by Price and Mueller was that pay is only significant if it is highly valued. However, some nursing studies tend to neglect the importance extrinsic rewards, such as pay, union coverage, and bargaining practices as aspects of job satisfaction, which may be acceptable in the US but not in unionized workplaces within Canada and the UK.

Being unionized has been associated with lower job satisfaction (Artz, 2010; Bryson, 2010; Pittman, 2007). In a cross-sectional study in the United States (N=2274) that examined differences in job satisfaction levels between RNs who were or were not unionized, Pittman (2007) found that non-members had statistically significant higher overall satisfaction than members of union ($p<.05$). However, union members had higher satisfaction with wages, than non-members. The literature reveals that unionized environments inspire to have higher pay; however, evidence demonstrates that working conditions are less desirable in unionized environments (Artz, 2010; Bryson, 2010; Pittman, 2007). This is important because most nurses in Canada work in unionized environments.

Many researchers have concluded that the rationale for lower job satisfaction among unionized workers is that they have the opportunity to voice concerns freely to management, instead of quitting, or being fired from their jobs (Borjas, 1979; Davis-Blake & Pfeffer, 1990; Freeman & Medoff, 1984; Gordon & Denisi, 1995). Another reason why union workers appear less satisfied is because less satisfied people pick union jobs (Artz, 2010; Bryson et al., 2004; Bryson, 2010). However, this argument is not relevant in Canada because most nursing workplaces are unionized and Canadian nurses have no choice but to be unionized.

In conclusion, inadequate resources, increased workloads, and poor nurse-to-patient staffing ratios are significantly related to nurse's job satisfaction. Furthermore, intrinsic and extrinsic rewards are important for staff motivation, which in turn are related to job satisfaction; however, Canadian nurses are rarely given bonuses or increased pay as a reward because they are unionized. Although there is much research on inadequate resources and nursing, there is minimal research that relates specifically to medical-surgical nurses, and there is no research that relates specifically to Canadian medical surgical nurses and unionized environments.

Positive scheduling climate. Flexible work schedules implemented by management allow staff independence and power over their schedules (Ellenbecker et al., 2007; Klemm & Schreiber, 1992). Flexible scheduling is closely related to control. Although there is contradictory evidence of the influence of shift work, length of shifts, and working full time on job satisfaction, nonetheless, having the option of choices and a flexible schedule is a central theme related to job satisfaction throughout the literature. However, this is challenging in Canada because of unionized workplace environments. Union contracts generally have strict policies regarding how many weekends and shifts that nurses must work; therefore, flexible scheduling is more of a challenge in these environments.

A great deal of research reports that inflexible scheduling that disallows nurse choices leads to decreased job satisfaction (Aiken et al., 2001; Brooks & Swailes, 2002; Flynn, 2003; Galinsky et al., 2011; Klemm & Schreiber, 1992; Kovner et al., 2009). For example, Galinsky et al. (2011) found that job satisfaction is positively linked to access to flexibility, based on the findings that 60% of Americans employed in goods producing and services industries, with high access to flexibility were satisfied with their jobs, compared to only 22 % of employees with low access to flexibility. Furthermore, not only was job satisfaction associated with flexible work schedules, but also just knowing that flexibility was an option was reassuring for employees. Specific to nursing, Shields and Ward (2001) found that influence over shift patterns and realization of preferred shift pattern was positively associated with overall job satisfaction. However, few nursing units offer flexible scheduling for their staff, particularly in unionized environments. Therefore, future research should focus on the relationship between job satisfaction and inflexible scheduling particularly in Canadian medical-surgical nurses.

The literature comparing job satisfaction between part-time and full time employees is contradictory. However, the majority of literature demonstrates that part-time nurses are more

satisfied than full time nurses (Conway & Briner, 2002; Eberhardt & Shani, 1984; Fenton O'Creevy, 1995; Fields & Thacker, 1991; Price & Mueller, 1981; Sinclair et al., 1999). Based on their findings, Conway and Briner concluded that full time employees may feel they are more committed to the organization over the years but have never been rewarded; thus, becoming resentful from the lack of recognition, and resulting in lower job satisfaction. Interestingly, the Australian Institute of Health Welfare (AIHW, 2008) statistics show that the percentage of part-time and casual nurses (nurses working less than 35 hours week) is 49.8%. In 2005 Canadian statistics found that of nurses in hospitals 55.5% of RNs are full time, 33.3% of RNs are part time, and 10.1 % of RNs are casual employees (Health Canada, 2005). Researchers conclude that the rationale for choosing part-time work may be related to the general benefits of part-time as having greater flexibility, which can be essential for some nurses primarily because traditional child care roles fall to women (Lumley et al., 2004).

On the contrary, some studies report that full time nurses are more satisfied than part-time nurses (Hall & Gordon, 1973; Miller & Terborg, 1979). Hall and Gordon (1973) concluded that part time female nurses had more role overload, and more home pressures than women in other groups (e.g. volunteering). Additionally, part time work for some women represents an incomplete resolution of the internal conflict about a career, a compromise between working full time and not being employed at all. Other studies reveal no significant differences in job satisfaction between full time nurses and part-time nurses (Krausz, 2000; Steffy & Jones, 1990; Vecchio, 1984).

The research literature generally supports that working unpaid overtime, shifts other than days, working weekends, irregular shift patterns, 12-hour shifts or more than 40 hours per week cause higher levels of nurse dissatisfaction (Gowell & Boverie, 1992; Kovner et al., 2009; Ma et al., 1993; Ruggiero, 2005; Shader et al., 2001; Shields & Ward, 2001; Shields, & Wilkins, 2009; Strachota et al., 2003). Several studies have found that nurses working 8 to 10 hour shifts compared to 12 hours

were shown to have greater satisfaction (Gowell & Boverie, 1992; Todd et al., 1993). An interesting observation by Gowell and Boverie was that nurses working in areas, such as PACU, OR, and pediatrics, who had the lowest stress scores and highest satisfaction, did not work 12 hours shifts. On the other hand, some of the literature supports that nurses working 12-hour shifts were more satisfied, than nurses who worked less than 12 hour shifts (Stone et al., 2006; Ugrovics & Wright, 1990). Furthermore, some researchers found no significant differences in nurses who worked 8 hour or 12 hour shifts (Hoffman & Scott, 2003; Jennings & Rademaker,1987). Overall, evidence is mixed and minimal evidence focuses specifically on medical-surgical units, therefore, future studies should focus on medical-surgical nurses and scheduling.

Negative effects of shiftwork are well documented throughout the literature, and are believed to occur as a consequence of the mismatch between the internal timing system of the shift worker and external time cues, such as light/dark cycles (Barton & Folkard, 1991). Barton and Folkard (1991) found that night shift nurses reported significantly higher levels of stress ($p<.05$); however, there was no significant difference in job satisfaction between day and night nurses. Barton and Folkard also found that temporary as opposed to permanent night nurses reported the highest levels of stress ($p<.05$) and were less satisfied than permanent night nurses. In essence, nurses who rotated shifts without the ability to choose shift rotation were significantly less satisfied (Barton & Folkard, 1991). Similarly, several studies found that nurses who chose to work night shifts had higher satisfaction (Barton & Folkard, 1991; Robson & Wedderburn, 1990; Ruggiero, 2005; Shields & Ward, 2001). Robson and Wedderburn concluded this could be because it minimized domestic problems, particularly with young pre-school children at home. Other rationales for choosing nights are the benefits, such as shift premiums, less supervision, and family obligations.

In conclusion, the literature supports the contention that an important component of nurses' job satisfaction is the perception of control over their own schedules. Although, there are

contradictory results of who is more satisfied between: part time vs. full time, day shifts vs. night shifts, and 8 hour vs. 8 hour + shifts, the overall theme in this section is that flexible work schedules increase nurse job satisfaction. However, this is a challenge in a unionized environment.

Nursing Competence. Assessment Strategies, Inc. (2012) refers to the overall level of competencies as general written behavior statements that reflect the knowledge, skills, abilities, attitudes and judgment required for effective performance in the certain profession. Specific to nursing, the Canadian Nurses Association (CNA; 2000) defines continuing competency as the "ongoing ability of a nurse to integrate and apply the knowledge, skills, judgement, and personal attributes required to practise safely and ethically in a designated role and setting" (p.4). Although there is some controversy as to what factors should be included in nursing competencies, factors that have been associated with nursing competency throughout the literature are age, professional experience (Raikkonen et al., 2007), education/professional development (Istomina et al., 2011; Raikkonen et al., 2007), and a higher level of independence (Istomina et al., 2011).

Many studies support the notion that lack of competence can influence job satisfaction and turnover (Choi, 2010; Oermann et al., 2010; Tyler et al., 2012). Choi (2010) found that ethical, personal, esthetical, and scientific competence were positively associated with job satisfaction. Tyler et al. (2012) found that individuals who lack clinical competency also had lower self-efficacy and less job satisfaction ($p<.05$), compared to nurses who rated their clinical performance higher. Moreover, not only has nursing competency been related to nurse job satisfaction but also to nurse turnover (Nursing Executive Center, 2005).

New graduates who lack the skills for transition to bedside nurses are more likely to be dissatisfied and resign than experienced hires; 75% of new graduate nurses leave their job within the first year (Nursing Executive Center, 2005). Researchers conclude that problems with nursing

competence is associated with students being unaware they were learning the ideal rather than the norm (Kramer, 1974). Interestingly, many new graduates are first employed on medical-surgical units.

Nursing competence is associated with increasing age, education, and professional experience (Raikkonen et al., 2007; Sparks, 2012). For example, in a cross-sectional nursing study (N=451) that examined generation differences, Sparks (2012) found that Baby Boomer nurses scored significantly higher on competence than Generation X nurses ($p<0.015$). On the contrary, Tzeng (2004) found that older staff assessed their own patient care skills to be worse than younger staff.

In conclusion, nursing competence is affected by multiple factors. Although factors may vary, common factors include age, education, and experience. A common theme is that nurses who perceive their nursing skills as strong, will rate themselves as being more competent and consequently more satisfied with their job.

In summary, based on a review of the related literature, organizational factors that affect job satisfaction include: team collaboration, nursing management, professional practice, staffing and resources, positive scheduling climate, and nursing competence. However, further research is needed to specifically address medical-surgical nurses, as they are the least satisfied group with the largest number of nurses.

Measuring Job Satisfaction

There are multiple tools to measure employee job satisfaction; however, there are still several problems with measuring this concept. Issues related to measuring job satisfaction can be rooted back to the complexity of defining the concept, in part because the affective component of job satisfaction is thought to be episodic, rather than chronic (Hulin & Judge, 2003). In other words, the actual definition can be considered subjective and is based on individual perspective. This section

reviews the literature on the most commonly used job satisfaction tools, including multiple and single item measurements.

Tools to measure job satisfaction are either based on multiple items or single items. There is a definite difference between the two types of measures. Multiple item or facet-based tools are the sum of specific facets (e.g. pay, promotions, coworkers, supervision, recognition, working conditions, and management), whereas single item tools are based on a global measure of overall job satisfaction. An essential factor in selecting a tool to measure job satisfaction is reliability and validity. Reliability is how well a particular tool, will produce similar results in different circumstances, assuming nothing else has changed (Roberts et al., 2006). Validity is the closeness of what we believe we are measuring to what we intended to measure (Roberts et al., 2006).

Multiple item measurement tools. When using a multiple item instrument, overall job satisfaction is measured by the sum of the facets (Judge & Klinger, 2008). There is controversy regarding finding the accurate measure of "overall" job satisfaction by using a multiple item tool. Job satisfaction research has been carried out for over 40 years and during this time numerous multiple item measurements have been developed. Among the most frequently cited in the literature are the Minnesota Satisfaction Questionnaire (Weiss et al.1967), Index of Work Satisfaction (Stamps & Piedmonte,1986), Work Quality Index (Whitley & Putzier, 1994), and Mueller and McCloskey's (1990) Satisfaction Scale.

The Minnesota Satisfaction Questionnaire (MSQ: Weiss, et al.,1967), one of the most widely used tool to measure job satisfaction, was developed in 1967. There are two long forms (Weiss1967; 1977;100 items) and one short form (Weiss 1967; 20 items). The MSQ measures intrinsic satisfaction, extrinsic satisfaction, and overall satisfaction. Moreover, the MSQ short form is reliable (reliability coefficient ranged from 0.77 or above) and valid (construct validity ranged from 0.03 to

0.12; Weiss, et al., 1967). However, this tool is criticized for been too lengthy, with the long form expected to take between ten and fifteen minutes and the short form is expected to take approximately five minutes to complete.

Stamps and Piedmonte's (1986, 1997) Index of Work Satisfaction (IWS) has been used in a few nursing studies (Best & Thurston, 2004; Gowell & Boverie, 1992). This tool, which has 19 items, has well documented internal consistency and validity, with Cronbach's alpha of .82 reported for the total scale (Best & Thurston, 2004). Overall, the purpose of this instrument is to identify priority areas for change by translating staff satisfaction into discrete areas amenable to correction (Stamps, 1997).

The Work Quality Index (WQI) is a 38 item scale that is unique because it was specifically designed to measure nursing workplace satisfaction (Whitley & Putzier, 1994). The tool is made of six subscales: professional work environment, autonomy, work worth, professional relationships, role enactment, and benefits. This instrument has demonstrated reliability, with a total summative Cronbach's alpha score of .94, and with all the items having scores greater than .72 (Whitley & Putzier, 1994). Several nursing studies have used the WQI (Koelbel et al., 1991; Larrabee et al., 2003; Whitley & Putzier, 1994). This tool is insightful for factors that influence job satisfaction, but there is no specific question regarding the overall perception of job satisfaction. Furthermore, this scale is a considerable participant burden because it is lengthy.

Mueller and McCloskey's (1990) Satisfaction Scale (MMSS) is a well-known tool to measure job satisfaction among nurses. This scale has 33 items in which participants are asked how satisfied they are with different aspects of their current job (e.g., benefits, opportunity). This tool was designed specifically for nurses employed in hospitals but can be used for nurses in other settings as well. A five-point Likert scale is used to measure each item. This tool has 8 different domains, and

is considered reliable with four of the subscales with alphas of 0.70 or higher. Additionally, the MMSS met the standards for a reliable and valid measure of nurses' job satisfaction (Mueller & McCloskey, 1990). A few studies have used the MMSS (Molinari & Monserud, 2008; O'Brien-Pallas, 2010). This scale has an overall reliability of 0.90 (Chaboyer et al., 1999). Although tested for reliability and validity, nonetheless, this tool does not address the individual nurse's overall perception of job satisfaction.

Overall there are several common multiple item instruments that are used to measure job satisfaction. Although, they all have demonstrated acceptable reliability and validity, nonetheless, job satisfaction is also about how it is perceived by the individual. While there are many factors that influence job satisfaction, a tool that allows individual perception was deemed to be most relevant for the current study.

Single item measurement tools. Single item instruments measure the overall job satisfaction in one question. Numerous nursing studies have used a single item tool (Hoel & Cooper, 2000; McGilton & Pringle, 1999; Nagy, 2002; Rodwell & Demir, 2012; Sawatzky & Enns, 2012; Scarpello & Campbell, 1983; Wanous et al., 1997) and found numerous benefits. Some examples of single item measures are Likert numeric and visual analog scales; for example Stogdill's (1965) Met Expectations Scale and Stinson's (1981) Propensity to Stay Scale.

Single-item measures have been criticized for low reliability (Scarpello & Campbell, 1983). Nonetheless, reliability and validity have been established in a number of studies (Dolbier et al., 2005; McGilton & Pringle, 1999; Wanous et al., 1997). For example, McGilton and Pringle (1999) used a single item tool called the Visual Analogue Scale (VAS). The VAS was tested for reliability via test-retest methods, with ten nurses completing the VAS twice, 10 days apart; the Pearson Product Moment Correlation Coefficient between those repeated measures was .95. Additionally, Brief and

Roberson (1989) found the VAS to be a valid way of measuring job satisfaction because this instrument captures the respondents' affective reactions to a number of work domains. Furthermore, this type of scale allows the respondents to combine aspects of the situation as they ordinarily think of them. In a large meta-analysis study (N=1735) of single-item measures of overall job satisfaction (28 correlations from 17 studies), that examined the use of single-item measures of job satisfaction, Wanous et al. (1997), found the reliability for single-item measures of job satisfaction to be .67.

In summary, job satisfaction is a complex phenomenon that has received increased attention in nursing over the past several decades. There are multiple ways to measure satisfaction and there are various tools that measure satisfaction. Benefits to single item measures include 1) takes up less space/ more cost-effective; 2) less time consuming/less participant burden; 3) ability to measure changes in global job satisfaction; 4) ability of a global measure to capture some factors of the job not in a multiple-item scale and that are perceived as important to the employee (Ironson et al., 1989; Scarpello & Campbell, 1983; Wanous et al., 1997). Although many of the items on multiple item scales are tested for validity and reliability, it is still unlikely that all of the items will represent all areas of a specific facet (Wanous et al., 2002). For example, nurse resources is made up of different components such as pay, benefits, equipment etc.

Although both types of measures were considered for this study, by using our framework as a guide, many of the facets in multiple item measures are factors that we will already be measuring as influencing factors. Global job satisfaction and facet job satisfaction do not measure the same construct (Highhouse & Becker, 1993; Scarpello & Campbell, 1982; Smith et al., 1969). Single item measures of job satisfaction are used in different circumstances; for example it is useful for measuring the overall perceived level of job satisfaction in certain units or change in overall job satisfaction over time (Scarpello & Campbell, 1982). Therefore, a single item measure of job satisfaction was used in the current study.

Bullying

This section provides a review of the literature on bullying, and the relationship between job satisfaction and bullying. Furthermore, this section explores different ways of measuring workplace bullying, and highlights individual perception as a key component to addressing bullying. In essence, the goal of this section is to use the OFPNR as a guide to identify common themes and short comings of previous studies relating to bullying and job satisfaction. Although bullying can fall under the influencing factors of collaboration, bullying is addressed separately in this review of the literature because this concept was a central component of the current study.

Workplace bullying is an escalating problem (Einarsen et al., 2011; Johnson, 2009; Salin, 2003; Strandmark & Hallberg, 2007) and is one of the most common forms of proactive aggression in workplaces (Griffin & Gross, 2004; Johnston et al., 2010; Lewis, 2001; Yildirim & Yildirim, 2007). Furthermore, bullying behaviors are especially prevalent among nurses (Johnston et al., 2010). These behaviors commonly include humiliation in front of others, isolation, exclusion, intimidation, and gossiping (Murray, 2009; Stelmaschuk, 2010).

Bullying has significant consequences for individuals (e.g. depression, anxiety) and organizations (e.g. job dissatisfaction; Hallberg & Strandmark, 2006; Hutchinson et al., 2006a; Hutchinson et al., 2010; Johnson & Rea, 2009; Quine, 2001; Tinaz, 2006; Yildirim, 2009). Despite the severity of bullying outcomes, bullying behaviors are rarely recognized or addressed; thus, the need for this study was well justified.

The majority of bullying research demonstrates that there are organizational and person factors, that contribute to bullying (Bjorkqvist, et al., 1994; Einarsen et al., 1994; Hoel & Cooper, 2000; Katrinli et al., 2010; Zapf, 1999) and that it is a multicausal phenomenon. Furthermore, central to this study is the theme that bullying is negatively correlated with job satisfaction (Bjorkqvist,

2001; Cowie et al., 2002; Duddle & Boughton, 2007; Einarsen, 2000; Hegney et al., 2006; Hutchinson et al., 2006a; Murray, 2009; Quine, 2001).

Comparing different studies on bullying can be problematic because different researchers have used somewhat different definitions, and different strategies to measure bullying (Salin, 2001). Nonetheless, the following review of the bullying literature has been organized within the context of the OFPNR. Thus, research relating to bullying will be discussed within the framework of influencing factors of job satisfaction, to include person factors (i.e. demographics) and organizational factors (nurse/nurse or MD/nurse collaboration, nursing management, staffing and resources, positive scheduling climate, and nursing competence). Furthermore, consequences of bullying and the different tools to measure bullying will be explored in this section.

Influencing Factors and Bullying

The relationship between bullying and influencing factors will be discussed in this section. Person and organizational factors will be addressed.

Person factors include demographic characteristics, such as age, years of experience, education, and, gender. The goal of this section is to review the literature on bullying, and to identify shortcomings of previous literature.

Age. Although a few studies have found no significant relationship between age and bullying (Quine, 2001; Vartia, 1996), the majority of literature demonstrates that younger nurses are more likely to be bullied than older nurses (Clendon & Walkder, 2012; Griffin, 2004; Kamchuchat et al., 2008; Pai & Lee, 2011; Rodwell & Demir, 2012; Yildirim, 2009). In a cross-sectional study (N=212), that examined bullying behaviors among RNs in acute care settings, Vessey et al. (2009) reported that staff RNs who worked 5 or less years on a unit were bullied the most as compared with staff RNs who worked 6-15 years. Furthermore, Vessey et al. also found that bulling occurred most

often on medical-surgical units. Similarly, in a cross-sectional study (N=286), that examined the relationship between bullying and age, with the majority of nurses working on wards or special care areas (i.e., ICU or operating rooms), Yildirim (2009) found that bullying was negatively associated with a nurse's age ($p<0.01$). Importantly, Griffin (2004) reported that not only are novice nurses most often targets of bullying, but they also have high turnover rates, which can reach 60% in the first year of nursing. Kamchuchat et al. (2008) also found that younger age was a risk factor for workplace violence, and concluded that this may be related to lack of work experience and lower education, resulting in a nurse's inability to handle difficult situations. Although many studies agree that younger nurses are most often the targets of bullying, the literature is vague as to which type of nurses are bullied most.

Years of experience. Age and years of experience generally go hand in hand**.** Therefore, not surprisingly the majority of literature reveals that decreased nursing experience is associated with higher levels of bullying (Griffin, 2004; Hegney et al., 2003; McKenna et al., 2003; Randle, 2003; Rodwell & Demir, 2012; Vessey et al., 2009). For example, Vessey et al. (2009) found that medical-surgical units had the highest levels of bullying with senior nurses being the greatest perpetrators, and nurses with 5 or less years were bullied the most. Additionally, targets were most often staff RNs with 5 or less years of experience on the unit. Vessey et al. concluded that experienced nurses may resent recent graduates because they have a higher level of education, but are still clinically naïve. Vessey et al. also concluded that less experienced nurses did not have organizational supports for dealing with bullying, and poor management contributed to the culture of bullying.

On the other hand, several studies have found no significant differences between years of experience and bullying (Johnson & Rea, 2009; Simons, 2008; Stelmaschuk, 2010; Yildirim, 2009). Simons (2008) found no statistically significant differences between the bully scores for newly licensed RNs (n=403) and those who held their nursing license for more than 36 months (n=107).

Simons concluded that further investigation was needed because the sample of RNs who had their license for more than 36 months was relatively small. Another limitation to this study was that the findings were not stratified according to type of work setting (e.g. rural vs. urban, or community vs. hospital unit). Additionally, the instrument used to measure bullying did not control for all the factors that are known to predict turnover, including job satisfaction factors.

Education. The literature in regards to education and bullying has demonstrated mixed results. A number of studies concluded that there is no relationship between education and bullying behaviors (Kamchuchat et al., 2008; Lewis & Blumenreich, 1993; Pai & Lee, 2011). However, in a cross-sectional study (N=521), Pai and Lee (2011) found that master's degree nurses were thought to be less vulnerable to violence. Likewise, in a survey of Thai nurses (N=545), that examined workplace violence towards nurses among numerous units (e.g. surgical, medical, operating room, pediatrics etc.), Kamchuchat et al. (2008) found that training related to violence prevention and control decreased the odds of experiencing verbal violence by approximately 40%. Kamchuchat et al. concluded that lower education could be the result of a nurse's inability to handle difficult situations.

Gender. The majority of the general research literature demonstrates that women are more likely to be victims of bullying behavior (Bjorkqvist et al., 1994; Ferrinho et al., 2003; Hader, 2008; Salin, 2001). It follows that bullying tends to occur more frequently in female dominated workplaces. Interestingly, nurses are considered to be a higher-risk group for exposure to violence than any other female dominated professions (Gunnarsdottir et al., 2006; Hutchinson et al., 2010; Kamchuchat et al., 2008; Quine, 2001; Vartia & Hyyti, 2002). For example, Gunnarsdottir et al. (2006) completed a study of lifestyle, harassment at work, and self-assessed health of Icelandic female flight attendants, nurses, and teachers, and found that nurses reported more bullying, physical violence, and threats, compared to flight attendants and teachers.

Non-nursing bullying studies reveal that the majority of perpetrators are men (Craig & Pepler, 1997; Einarsen & Skogstad, 1996; Hoel et al., 2001). In a large British study (N=5288) that examined bullying in 70 organizations including private, public, and voluntary sectors among workers, supervisors, middle and senior management, Hoel et al. (2001) reported that men were far more likely to be bullied by other men (62.2%); likewise, women were more likely to be bullied by other women (37.3%). Additionally, Hoel et al. (2001) conveyed that male workers and supervisors were more likely to be the victims than women. Interestingly, bullying behaviors differed between men and women. The behavior that was most significantly different was that men were more likely to be recipients of practical jokes than women ($p<.001$). However, this was a non-nursing study.

Specific to nursing, not only are females more likely to be the victims of bullying behaviors but they may also be more likely to be the perpetrators of bullying (Pai & Lee, 2011; Quine, 2001; Vessey et al., 2009). On the other hand, Hegney et al. (2003) found that male nurses were more likely to be exposed to workplace violence than female nurses ($p<0.003$). Hegney et al. concluded that the reason for the different findings than the majority of gender nursing literature was because of the small sample size of male nurses. Additionally, when measuring workplace violence Hegney et al. included abuse from patients, which may also have impacted on these disparate results

Unit Type. A major theme throughout the nursing literature is that bullying is a major problem in nursing; however, very few studies specify the type of unit (Pai & Lee, 2011). Studies that have addressed the type of unit focused on intensive care units (ICUs; Oztunc, 2006), psychiatric units (Foster et al., 2007; Inque et al., 2006) or emergency departments (ED; Johnson & Rea, 2009). Johnston et al. (2010) noted that bullying occurs more in areas of nursing that are fast paced and high stress, such as EDs and medical/surgical floors. However, these findings are not consistent with other studies. Specific to medical-surgical nurses, in a cross-sectional study that explored nurses' self-rated perceptions of violence across 94 medical-surgical units (N=2487), Roche et al. (2010)

found that the majority of nurses experienced emotional abuse. Thus, since all units in this study were medical/surgical units, clearly violence is not restricted to psychiatric units, ICU or ED departments.

The nursing literature consistently reports that medical-surgical units have higher levels of bullying than other units (Johnston et al., 2010; O' Connell et al., 2000; Stelmaschuk, 2010; Vessey et al., 2009). In a study exploring perceptions of frequency and patterns of bullying behavior experienced by RNs across the United States (N=212), Vessey et al. (2009) found that nurses on medical-surgical units had higher rates of bullying than other areas, followed by critical care, EDs, operating room/post anesthesia care units, and obstetric units. Likewise, in a cross-sectional correlational study, that examined the incidence of workplace bullying at two Midwestern academic healthcare institutions and if there was a relationship between emotional exhaustion among nurses and other hospital staff (N=299), Stelmaschuk (2010) found a significant difference in bullying intensity by clinical specialty. Nurses on surgical units, had significantly higher bullying behaviors than other areas ($p<.05$), followed by OR nurses. Therefore, bullying is clearly an issue for medical/surgical nurses. However, few studies have explored the factors that influence bullying on medical/surgical units.

In summary, the research literature demonstrates less than consistent evidence in regards to the relationship between bullying and person factors, such as age, years of experience, gender, education, and type of unit, thus, substantiating the need to investigate these factors further. In addition, medical-surgical units have one of the highest levels of bullying, and lowest job satisfaction; however, minimal research has specifically investigated factors affecting bullying on medical-surgical units. Moreover, although person factors may predispose victims to bullying, it does not explain why. Therefore, it is important to explore alternative influencing factors that may cause bullying on medical/surgical units.

Organizational factors. Still following the OFPNR framework, the literature related to the relationship between bullying and organizational factors, including physician/nurse and nurse/nurse collaboration, nursing management, professional practice, positive scheduling schedule, resources and staffing, and nursing competence was explored in this section.

MD/nurse and nurse/nurse collaboration. As discussed in the previous section, collaboration among healthcare professionals is essential for job satisfaction (Chang et al., 2009); thus, it is not surprising that a central theme throughout the literature is that bullying is negatively correlated to job satisfaction (Agervold & Mikkelsen, 2004; Duddle & Boughton, 2007; Hegney et al., 2006; Hoel & Cooper, 2000; Vartia, 1996). The majority of literature supports the contention that areas with poor working relationships have higher levels of bullying behaviors (Einarsen et al., 1994; Hoel & Cooper, 2000; Leymann, 1993). This section will focus on bullying relationships between nursing peers, which is also known as horizontal bullying and bullying between nurses and their managers or MDs, which is known as vertical bullying.

Horizontal bullying is a commonly reported occurrence in nursing, with numerous studies demonstrating that senior nurses are the major perpetrators of bullying (Dellasega, 2011; Johnson 2009; McKenna et al., 2003; Quine, 2001; Rodwell & Demir, 2012; Vessey et al., 2009). Based on a cross-sectional study, that explored the prevalence and effects of workplace bullying on the work productivity of novice nurses (N=197), Berry et al. (2012) found the major perpetrators were senior nurses, followed by nurse leaders, then physicians. Based on their findings Rodwell and Demir concluded that oppressed groups have less job control and power, which leads them to being submissive and silent in confrontation with authority. In horizontal bullying, senior nurses use their informal power to intimidate other, often more junior nurses who have little power and few choices but to accept the bullying behavior or to leave the organization all together. In a fairly recent study of horizontal violence within the University Health Network in Toronto (N=160), Mallette (2010) found

that 95 % of the participants had witnessed horizontal violence and 71% thought they had been targets of horizontal violence. Likewise, in a cross-sectional study of RNs in the US (N=212) that examined perception of frequency and patterns of bullying behavior, Vessey et al. (2009) found that senior nurses were identified most often as being the bullies, followed by charge nurses, nurse managers, then physicians.

On the other hand, in a cross-sectional correlational study that examined the incidence of workplace bullying in two medical centers, among RNs, LPNs, unit clerks, patient care assistants, surgical technicians, and service technicians that work on nursing units, Stelmaschuk, (2010) found that physicians were the most frequent perpetrators, followed by RNs.

Conflict with physicians has been identified as a major stressor in the nursing work environment (Greenfield, 1999). Nurses may face physical and verbal abuse when in conflict with physicians (Rosenstein, 2002). In a medical-surgical nursing study in the US (N=144), that explored collaboration among nurses and physicians, Nelson et al. (2008) found that nurses and physicians communicated differently, nurses were more likely to support/agree, while the physicians were more likely to give an opinion. Nelson et al. thought the rationale was related to the lower level of nurse's assertiveness and perceived power differences. Interestingly, Nelson et al. found that nurses with more education and experience perceived their collaboration with physicians as higher than those with less education and experience.

Management. The literature demonstrates contradictory results related to the greatest perpetrators of bullying, ranging from physicians, other health care professionals, colleagues, patients and their families, and managers (Farrell et al., 2006; Hegney et al., 2006; Kwok et al., 2006). Nonetheless, a central theme throughout the literature reveals that managers are the biggest bullies (Cleary et al., 2010; Hoel & Cooper, 2000; Johnston et al. 2009; Johnson & Rea, 2009; Quine, 2001; Thobaben, 2011; Ulrich et al., 2005). Nurse managers also play a leading role in controlling bullying

(Johnston, et al., 2009), as they have a professional responsibility to recognize early signs of negative behaviors in the workplace and to address bullying behaviors accordingly. Johnston et al. (2009) reported that managerial bullying occurs because of their perceived lack of personal power and personal insecurities, which may be related to poor interpersonal skill development, low self-esteem, and a consequence of being promoted beyond their experience and ability. This section will focus on bullying relationships between nurses and their managers.

Specific to nursing, in a cross-sectional study (N=1100), that examined the association between bullying and occupational health outcomes, among nurses, therapists, administration staff, doctors, clinical psychologists, other professionals, and unqualified staff, Quine (2001) found that the bully was most likely to be a senior manager, followed by someone at the same level of seniority. Based on a study of currently licensed RNs (N=1783), that explored how RNs view the work environment and the nursing shortage based on magnet status of their organizations, Ulrich et al. (2005) found that more respect from managers would be very likely or somewhat likely to cause them to reconsider leaving their current position. Thus, vertical bullying by managers can have consequences on organization, such as influencing the nurses' decision to leave their jobs. (see also chapter 1 for discussion of bullying consequences)

Several researchers report that some managers use bullying as a style of management (Hoel & Beale, 2006; Hutchinson et al., 2006a; Ironside & Seifert, 2003; Johnson 2009; Lutgen-Sandvik et al., 2007). Certain leadership styles are associated with a higher incidence of bullying behaviors among staff. For example, autocratic leaders are more likely than transformational leaders to be bullies (See also next section re Leadership Styles). There are mixed findings in regards to managerial awareness of their bullying management styles (Agervold & Mikkelsen, 2004; Barber, 2012). Some studies reveal that managers are unaware and appear shocked and horrified to realize they are being

perceived as a bully (Barber, 2012). Moreover, studies reveal that bullies do not necessarily perceive their actions as intentionally injurious (Agervold & Mikkelsen, 2004).

Thus, a central theme throughout the literature is that managers are the biggest sources of bullying; moreover, specific leadership styles reinforce bullying behaviors among the unit staff. Thus, bullying arises from organizational cultures that tolerate these negative behaviors in the workplace. Despite the severe consequences bullying has on workplaces, research consistently demonstrates that bullying is often ignored or addressed ineffectively (Johnston et al., 2009; Lewis, 2006; Vessey et al., 2009). Nonetheless, the first step to addressing bullying is to identify the problem and the factors that influence the bullying behaviors.

***Professional Practice*.** The literature indicates that professional practice environments influence bullying (Einarsen et al., 2003; Johnson, 2009; Laschinger at al. 2010: Lewis, 2006; Roche et al., 2010; Zapf & Einarsen, 2005). Conversely, employees who have opportunities for growth have elevated self-esteem (Laschinger, 1996). In a Canadian nursing study (n=415), that explored graduate nurses' perceptions of structural empowerment to their experiences of workplace bullying and burnout, Laschinger et al. (2010) found that more access to workplace empowering structures (i.e., access to information, resources, support, opportunities to learn and grow, job discretion and strong working alliances) was associated with less bullying. Furthermore, opportunities to learn and grow were rated highest out of all the empowering structures. Laschinger et al. concluded this was because many of the respondents were new to the profession; thus, having minimal nursing experience.

Overall, professional practice has been associated with bullying. Furthermore, opportunities for growth and learning will likely also give rise to more of a sense of control /autonomy in the workplace.

Autonomy/Control. Lack of control and imbalance in power have also been associated with bullying (Agervold & Mikkelsen, 2004; Baillien et al., 2011; Demir & Rodwell, 2012). In a study of blue-collar workers across 11 organizations (N=319), Baillien et al. (2011) found a positive association between workload and bullying behaviors ($p<.001$) and also found a negative association between autonomy and bullying ($p<.001$). High levels autonomy and empowerment, are associated with lower levels of workplace bullying (Baillien et al., 2011; Einarsen et al., 1994; Hoel and Salin, 2003; Leymann, 1996; Quine, 2001; Vartia, 1996; Zapf et al., 1996; Zapf, 1999). Specific to medical-surgical nurses, in a cross-sectional study that explored nurses' self-rated perceptions of violence across 94 medical-surgical units (N=2487), Roche et al. (2010) found that emotional abuse was lower when autonomy was higher ($p<.05$). Roche et al. also reported as emotional abuse increased, so did the amount of time required to complete nursing work.

In a cross-sectional study of nurses and midwives among different hospital wards (N=207), that explored the antecedents to and consequences of various forms of workplace aggression, Demir and Rodwell (2012) found that low job control was associated with internal emotional abuse ($p<.05$). Shared decision making, has also been found to influence bullying (Hoel & Cooper, 2000; Laschinger et al., 2003; Quine, 2001). Specific to nursing, Quine (2001) found that nurses who had less participation in decision-making and lower job control were more likely to report one or more types of bullying than other nurses.

Interestingly, many researchers have concluded that bullying behavior is learned by socialization into the culture of an organization, in which newly hired staff are often the victims, but as they gain power and status within the organization, they become the bullies (Farrell, 2001; Lewis, 2006; McKenna et al., 2003).

Resources and Staffing. The majority of literature reviewed reports that inadequate resources and inadequate staffing are inversely related bullying behaviors (Baillien et al., 2011; Einarsen et al., 1994; Hoel & Cooper, 2000; Roche et al., 2010; Salin, 2001; Vessey et al., 2009). The literature consistently reports that increased workload is positively correlated with bullying behaviors (Baillien et al., 2011; Einarsen et al., 1994; Hoel & Cooper, 2000; Yildirim, 2009). In a nation-wide survey of workplace bullying across a number of occupations and industrial sectors in Britain (N= 5288), Hoel and Cooper (2000) found that bullying was significantly related to higher workload ($p<0.001$). Likewise, Einarsen et al. (1994) found a significant relationship between bullying and work-load ($p<.001$) in their study of labour union members and members of the Norwegian Employers' Federation (N=2215). However, based on their findings, Einarsen et al. concluded that although workload was a significant organizational factor, leadership, role conflict, and work control were the most important factors in predicting the occurrence of bullying and harassment.

Specific to nursing, in a cross-sectional study (N=286), that examined the rate and nature of workplace bullying experienced by nurses in healthcare facilities across Turkey, Yildirim (2009) found that bullying was positively associated with work overload ($p<0.01$). Specific to medical-surgical nurses, in a cross-sectional study that explored nurses' self-rated perceptions of violence across 94 medical-surgical units (N=2487), Roche et al. (2010) found that increased workload, led to increased emotional abuse. Interestingly, tasks delayed per shift or tasks not done per shift were also significantly related to emotional abuse ($p<.05$). Furthermore, Roche et al. reported that as ward environments become less stable, perceived violence increases and patient care is affected.

Inadequate resources go hand in hand with workload/staffing; thus, inadequate resources influence bullying behaviors (Baillien et al., 2011; Vartia, 1996). In a study of blue-collar workers across eleven organizations (N=319), Baillien et al. (2011) found job demands increase the likelihood of being bullied over time, and job resources prevent the future occurrence of bullying behaviors.

There is minimal research on unions, pay, and bullying; nonetheless, studies report that workplaces that are more competitive for rewards (e.g. pay) or advancements can lead to bullying behaviors (Vartia, 1996). For example, in a study of Finnish Federation of Municipal Officials (e.g. office workers, food services and basic servicing tasks; N=949), that explored the work-related risks of bullying in the workplace, Vartia (1996) found envy, a weak superior, competition for tasks or advancements, and competition for the superior's favour and approval were most often perceived as reasons for bullying.

In summary, a central theme in the literature is that workload, and resources affect bullying. Furthermore, the relationship between unions and bullying needs more evidence to draw formal conclusions; however, important findings have been reported in regards to rewards and bullying.

Positive Scheduling Climate. A consistent theme throughout the nursing literature is that bullied employees report having less control over their work environment, including inflexible scheduling (Einarsen et al., 1994a; Hoel & Cooper, 2000; Rodwell & Demir, 2012; Vartia, 1996). Although there is minimal evidence with contradictory findings in regards to bullying and scheduling, nonetheless, the length of shifts, working full time, having the option of choices of shifts and flexible scheduling all influence the work environment.

Several researchers have found that nurses who work night shift/early morning shift perceive higher levels of bullying (Pai & Lee, 2011; Rodwell & Demir, 2012). In a cross-sectional study of nurses and midwives among different hospital wards (N=207), that explored the antecedents to and consequences of various forms of workplace aggression, Demir and Rodwell (2012) found that work schedule was a significant factor for workplace bullying. Additionally, Demir and Rodwell found a positive relationship between the work schedule of morning shifts and bullying, with morning shift workers more likely to experience bullying than other shift workers ($p<.05$). Rodwell and Demir

concluded that the less qualified staff were more likely to be given the least desirable work on the morning shifts, which may be the reason for these results.

Similarly, while there is minimal evidence with regards to full time/part time status and shift length and bullying. Qunie (2001) found that bullying behaviors are significantly higher for nurses who work full time, as opposed to part time ($p<.01$). These results may be related to more young, novice nurses working full-time at the time of this study

In summary, a central theme is that there is a relationship between scheduling and perceived bullying. Furthermore, more research is needed in the area of shift length and part time/full time status and bullying.

Nursing Competence. Several nursing studies report that low levels of nursing competency and self-efficacy can lead to bullying behaviors (Hutchinson et al., 2006; Hutchinson et al., 2010; Quine, 2001). In a review of the literature on theoretical understandings of bullying in nursing that explored how bullying can become normalised within an organizational culture, Hutchinson et al. (2006a) found that targets of bullying are isolated and labelled as stupid or less competent. Hutchinson et al. concluded that this behavior belittles the target's confidence even more and reinforces the bully's action by using their power, and cliques to isolate their victim.

In a sequential mixed methods study of Australian nurses in clinical, management, education or administration nursing roles (N=370), that tested a multidimensional model of bullying in the nursing workplace, Hutchinson et al. (2010) found that a common tactic of bullies was to erode professional competence and reputation. Hutchinson et al. concluded that the aim of this tactic was to make the target more vulnerable and to damage professional identity and limit career opportunities. Furthermore, Hutchinson et al. (2010) found that perpetrators would publicly question the skills and capabilities of nurses, which made targets appear less competent. On the other hand, in a large

nursing study in England (N=1100), that examined bullying and occupational health outcomes, Quine (2001) found that personal dispositions such as hardiness and self-efficacy can protect nurses against bullying. However, Quine concluded that the relationship between these dispositions and bullying need more research attention.

Summary. In summary, although bullying is related to numerous person factors and organizational factors, a central theme is that nurse managers appear to have the greatest control and influence over workplace bullying. While many of the organizational factors relate to each other, managers have the ultimate control to prevent, address, and control bullying behaviors among their nursing staff.

Measuring Bullying

Numerous tools have been developed to measure bullying. Ideally, the measurement tool for bullying should operationalize the central characteristics of the conceptual definition (Nielsen et al., 2010). Therefore, linking back to the definition of workplace bullying in the previous chapter, the workplace bullying tool should assess exposure to negative acts, the regularity and persistency of these acts, the process development of workplace bullying, and the power imbalance between target and the perpetrator (Nielsen et al., 2010).

Bullying is typically measured by using either the Self-labelling or the Behavioural Experience method. The Self-labelling (SL) approach is one of the most frequently used, and is usually applied by a single-item question whether or not one has been bullied. The purpose of the SL method is to calculate the prevalence rates of workplace bullying (Nielsen et al., 2010). Advantages are that it is quick and has high construct validity (Nielsen et al., 2010). However, this SL method does not offer insight into the nature of the behaviours involved; in other words, it just answers if someone is a victim, but not how the bullying took place, nor the consequences. This is a problem

because this method provides neither the insight into the rationale nor the outcomes of the bullying experience.

An alternative approach to measuring bullying is the Behavioural Experience (BE) method (Nielsen et al., 2010). This approach takes the nature, frequency, and duration of the unwanted behavior into consideration (Nielsen et al., 2010). This is significant because the BE approach includes the components that define bullying. An advantage of the BE method is that it does not allow respondents to label their experience as bullying; rather the researcher analyzes if they have been bullied. Agervold (2007) and Einarsen (1996) have found that not mentioning the word "bullying" results in a lower risk of the respondents being influenced by cognitive and emotional processes. A limitation of the BE method is that the power difference is not measured (Nielsen, 2009). However, the problem with measuring bullying is individual perception. For example, the perception of what people consider normal conflict and bullying can interfere with measurements.

The distinct difference between the SL and BE methods is that the self-labelling method includes a cognitive evaluation of whether the respondents feel victimised by the bullying behaviors, whereas the B.E. method investigates the persistency of different negative behaviors without taking the victimisation into consideration (Nielsen et al., 2010). Therefore, combining both methods, by measuring the respondents' exposure to persistent bullying behaviour and their perception of being victimised, is considered ideal as it captures all the characteristics included in the theoretical definition of workplace bullying (Nielsen, 2009). Moreover, by providing a definition of bullying the researcher can assume that the respondents are more likely to understand the concept and what is being assessed (Nielsen et al., 2010).

Instruments that have been used to measure bullying, but are not widely used in nursing include the Workplace Aggression Research Questionnaire (WAR-Q; Neumann, & Keashly, 2003) and the Bergen Bullying Index (BBI; Rizzo, et al., 1970). The original version of the WAR-Q

contained 60 items, which make it unappealing for participants because it is time consuming. The BBI measures the degree to which bullying is perceived to be a problem. The BBI is a global measurement of potential individual and organizational consequences of bullying and harassment. The tool consists of five items and has internal stability (Cronbach alpha=0.86). Moreover, this tool has been used in bullying studies of children (Olweus, 1990) and in organizational workplaces (Einarsen et al., 1994). Although this tool demonstrated acceptable reliability, limitations to this tool include that it does not distinguish between observers and victims (Einarsen et al., 1994) and it has not been used in many nursing studies.

Historically, one of the first tools to measure workplace bullying was the Negative Acts Questionnaire (NAQ), developed by Einarsen and Raknes (1997). The NAQ has been revised many times since it was first created; for example, the NAQ-R 29 (Hoel, et al., 2001), the Shortened NAQ (Notelaers & Einarsen, 2008), the revised NAQ-R (Einarsen et al., 2009) with 22 (plus the self-labelling question) items instead of the 29 items in the 2001 NAQ-R version, Salin's 2001 version.

The original English 23-item NAQ examined negative acts of a personal as well as a work-related nature (Einarsen & Raknes, 1997). Numerous studies have used the NAQ (Agervold, 2009; Einarsen & Raknes, 1997; Mikkelsen & Einarsen, 2001). This original scale has demonstrated high internal consistency, with Cronbach's alpha ranging from .84-.91 (Mikkelsen & Einarsen, 2001) and reportedly has good face and construct validity (Einarsen et al., 2009). Nonetheless, there were several limitations to this tool. According to Einarsen et al. the items are overly influenced by the perspectives of severely affected targets; additionally, the tool was developed at a time when most bullying research was confined to the Nordic countries; therefore, the validity of the tool was only tested within a limited Scandinavian cultural context. When the scale was translated to English, the face validly of some items was questionable (Einarsen et al., 2009).

The nine-item Short-Negative Acts Questionnaire (S-NAQ; Notelaers & Einarsen, 2008) is another revision of the NAQ. The items in this tool include negative acts directed at the person (e.g. gossiping) or at work (e.g. being withheld information), which can be perceived as bullying. Participants indicate how frequently they have been exposed to negative acts during the last 6 months. In a study (N=320) that examined Karasek's Job Demand Control Model in relation to workplace bullying in a large Belgian organization, Baillien et al. (2010) found all the items on the S-NAQ to be internally consistent at both time 1 (Chronbach's alpha: 77) and time 2 (Chronbach's alpha: 79); test-retest reliability was .66. Similarly, in a longitudinal study of Belgian employees (N=312), in which Rodriguez-Munoz et al. (2009) used the S-NAQ to investigate the cross-lagged relationships between bullying and job-related well-being, they found S-NAQ to have internal consistency (Chronbach's alphas between .76 and .87).

The 9 item S-NAQ matched from both a descriptive and a validity perspective. Construct validity for the 9 item version correlates above .85 with the original version of the NAQ (Notelaers & Einarsen, 2009). Moreover, the predictive validity demonstrates that the different clusters with the S-NAQ have similar correlates with measures of well-being as the cluster earlier distinguished with the NAQ. Additionally, construct validity was demonstrated by the self -labelling measures of the S-NAQ (Notelaers & Einarsen, 2009). Appealing advantages to this tool is it is much shorter than previous tools, and still retains acceptable reliability and validity. However, it has not been used very much in the literature and no nursing studies were found on this tool; thus, it was deemed not to be the best choice for the proposed nursing study.

The NAQ-R was created by Hoel, and colleagues (2001), to address the limitations of the original NAQ, for use in a variety of occupational settings. While the NAQ-R was tested on various UK occupations, and positions across organizational hierarchies (Hoel, et al., 2001), it was also easily adapted to Anglo-American cultures. The NAQ-R was first developed as a scale with 29 items, than

later abbreviated to a 22-item version (plus the self-labelling question) (Einarsen, et al., 2009). There are 3 dimensions to this questionnaire: work related bullying (7 questions; 1, 3, 14, 16, 18, 19, 21), personal bullying (12 questions; 2, 4, 5, 6, 7, 10, 11, 12, 13, 15, 17, 20), and physical intimidation (8, 9, 22). As far as the factors of the NAQ-R are concerned, the strongest correlations are found for work-related bullying, with the weakest correction found for physical intimidation.

This instrument has high internal stability, with three underlying factors: personal bullying, work-related bullying and physical intimidation as forms of bullying (Einarsen et al., 2009). All items are written in behavior terms with no mention of the word bullying (Simons, 2008). The NAQ-R has been used in several non-nursing studies (Einarsen et al., 2009; Hauge et al., 2007).

The NAQ-R has also been used in many nursing studies (Hoel & Cooper, 2001; Johnson & Rea, 2009; Lutgen-Sandvik et al., 2007; Simons, 2008). For example, in a descriptive study of Washington State emergency nurses (N=249), which explored workplace bullying, Johnson and Rea (2009) reported Chronbach alpha of .89 for the NAQ-R. Furthermore, Johnson and Rea found that nurses who were bullied were almost twice as likely to report that they were very likely intending to leave their current position in the next 2 years compared with those who had not been bullied. Likewise, in another study of RNs in Massachusetts (N=511), Simons (2008) found the NAQ-R to be a reliable tool, with internal reliability of 0.92.

In summary, there are numerous tools to measure bullying; however, the field of bullying research is relatively new; therefore, tools are still being tested and revised. Nonetheless, considerations of the most ideal tool for this study should include characteristics of the definition of bullying; the tool should be reliable, valid, and time efficient, as there were other tools that would be used in this research, and empirically tested in nursing research. Thus, the NAQ-R 22-item version (Einarsen, et al., 2009) was used for this study.

Summary

In summary, a central theme that has emerged is that bullying is influenced by many of the same factors that are related to job satisfaction including person and organizational factors, with managers being the key influencing factor. Furthermore, a common component to defining and measuring bullying is the significance of individual perception. Thus, tools to measure bullying should include characteristics of the bullying definition, with established reliability and validity and not be too time consuming. Therefore, the NAQ-R was selected to measure bullying behaviors in the current study.

Leadership Styles

This section complements previous segments of this literature review on job satisfaction and bullying. More specifically, this section explores the existing literature on different leadership styles and their relationship to bullying and job satisfaction. Furthermore, popular tools that have been traditionally used to measure leadership are reviewed, with the goal to establish the optimal measure of leadership for the current study. Although leadership styles can fit under the category of nursing management, it is being discussed separately because of its central role in this research study.

Historically, leadership has existed since the earliest civilizations (Stone & Patterson, 2005). In other words, humans have always organized themselves in a kind of hierarchical structure. Accordingly, managers and leadership styles have been studied for over two centuries. Over time, organizations have evolved from those with managers who possessed authoritarian style, to organizations where employees are generally more empowered, and encouraged through a more authentic leadership style (Stone & Patterson, 2005).

Several studies have reported that effective leadership increases job satisfaction (Albaugh, 2003; Hauge et al., 2007; Laschinger et al., 2012; McNeese-Smith, 1996; Taunton et al., 1997) and that effective leadership decreases bullying behaviors (Einarsen et al., 2009; Hauge et al., 2007;

Laschinger et al., 2012). Conversely, bullied employees have been found to report more job dissatisfaction than their non-bullied colleagues (Vartia & Hyyti, 2002).

As discussed in the previous section of this chapter, managers have been identified as the most frequent perpetrators of bullying; thus, leadership variables were of critical interest to the current study. Managers are central to the nursing environment, and influence the level of bullying on units (Agervold & Mikkelsen, 2004; Einarsen et al., 1994; Hauge et al., 2007; Leymann, 1990; Vartia, 1996), and staff nurse's level of job satisfaction (Albaugh, 2003; Hauge et al., 2007; Laschinger et al., 2012; McNeese-Smith, 1996; Taunton et al., 1997). For example, in a cross-sectional study (N=186) among blue collar workers, Agervold and Mikkelsen (2004) found that targets of bullying reported poorer management styles, than their non-bullied colleagues.

Non-effective leadership styles including: tyrannical, laissez-faire, autocratic, and non-contingent have been linked to increased bullying. For example, in a cross-sectional study (N=2539), that explored the importance of stressors at work in connection with different measures of workplace bullying among Norwegian employees, Hauge et al. (2007) found that bully targets and bystanders of bullying reported higher levels of tyrannical and laissez-faire leadership behaviours and conversely, lower job satisfaction than employees not involved in bullying behaviors. In another similar cross-sectional study (N=5288), Hoel and Cooper (2000) found that not only was laissez-faire associated with bullying but so were autocratic, and non-contingent styles as well.

On the other hand, effective leadership styles have been linked to lower levels of bullying behavior and higher job satisfaction (Duffield et al., 2009; Hauge et al., 2011; Laschinger et al., 2011; Laschinger et al., 2012). Positive leadership styles include: authentic, and transformational/transactional. Although many managers have moved from the traditional authoritarian type of leadership to embrace a more transformational/transactional leadership style,

unethical/bullying behaviours continue to increase; therefore, something is not working. Specific to nursing, several studies report that workplace bullying is still increasing in nursing populations (Laschinger et al., 2010; McKenna et al., 2003; Quine, 2001), despite the fact that transformational/transactional leadership is widely used by nursing managers. Thus, transformational leadership may not be the answer.

Authentic Leadership.

An emerging style of leadership, known as authentic leadership has been associated with positive work outcomes, such as job satisfaction (Avolio et al., 2004; Giallonardo et al., 2010; Laschinger et al., 2012; Walumbwa et al., 2008; Wong et al., 2010). Authentic leadership is a relatively new concept and, as such, is a growing phenomenon of interest among nursing workplaces (Laschinger et al., 2000; Laschinger et al., 2001; Laschinger et al., 2012; Wong et al., 2010). In fact, several studies have already noted an association between workplace bullying and authentic leadership (Frederick, 2014; Lashchinger & Fida, 2014; Laschinger et al., 2012).

In a recent Canadian cross-sectional study (N=342) that examined the link between authentic leadership and new graduate nurses' experiences of workplace bullying, burnout, job satisfaction, and intent to leave, Laschinger et al. (2012) found that authentic leadership had a significant inverse relationship with workplace bullying. Furthermore, authentic leadership influenced job satisfaction indirectly through workplace bullying. Finally, job satisfaction had a direct effect on job turnover intentions. Laschinger et al. concluded that leadership practices that promote a supportive work climate by discouraging negative interactions play an important role in retention of graduate nurses. Similarly, in another Canadian study (N=170), that examined the relationships between new graduate nurses' perceptions of preceptor's authentic leadership, work engagement and job satisfaction,

Giallonardo et al. (2010) found authentic leadership and nurse-nurse interaction to have one of the highest positive correlations ($p<0.01$).

Although, authentic leadership styles have been included in several studies that explore nurse satisfaction, only one study was found that explored the relationship between authentic leadership style, job satisfaction, and bullying. Despite the apparent positive outcomes of authentic leadership, much of the leadership research literature is often restricted to transformational and transactional leadership styles. Thus, there is a need for more research relating to authentic leadership, job satisfaction, and bullying.

Although positive leadership styles have similar characteristics, there are some unique differences that should not be overlooked, as they may be the key to dealing with bullying. Transformational leadership revolves around the process of changing and transforming people and therefore, transformational leaders are often charismatic and motivate employees by inspiring them, consider them individually, and stimulate their intellectual needs (Burns, 1978). On the other hand, authentic leaders are anchored by their own deep sense of self (self-awareness), thus, authentic leaders know themselves and remain true to their values; they choose leadership roles that are consistent with internal self-concepts and goals. Moreover, the outcomes for the two leaderships may differ, as transformational leaders often try to develop followers into leaders (Avolio, 1999; Bass, 1985), whereas authentic leadership focuses on follower's development toward achieving authenticity, which may not involve serving in a leadership role. In other words, authentic leaders do not just develop themselves as authentic but strive to develop authenticity in others as well.

In summary, a central theme that has developed in the leadership literature is that a manager's leadership style influences job satisfaction and workplace bullying. Furthermore, one nursing study (Lashinger et al., 2012) has shown that there is a relationship between the key factors of interest to

this study (i.e., job satisfaction, leadership style, and workplace bullying). However, their research focused specifically only on new graduate nurses and did not specify the type of nursing unit. Although, Laschinger et al (2012) certainly contributed to the nursing research on bullying and authentic leadership, further investigations particularly in medical surgical nurses are important because medical-surgical units employ the highest percentage of nurse and nurses in these areas have one of the lowest levels of job satisfaction, and highest bullying behaviors among staff nurses.

Measuring Leadership

There are several instruments that measure leadership behaviors. However, in this section a few of the more common types of leadership measures will be explored including the most widely used leadership instrument in nursing: The Multifactor Leadership Questionnaire (MLQ), and a new upcoming instrument: The Authentic Leadership Questionnaire (ALQ).

The Multifactor Leadership Questionnaire. Transformational leadership has been the major focus of leadership research since the 1980s. Accordingly, one of the most widely used instruments to measure this type of leadership is the Multifactor Leadership Questionnaire (MLQ; Bass, 1985), which includes, transformational, as well as transactional, and laissez-faire leadership styles. The questionnaire was based on Burns (1976) theory, which distinguished between transactional and transformational styles of leadership. Although the MLQ is a well-established, reliable and valid instrument, it does not include the measurement of authentic leadership, and therefore was not an appropriate choice for the current study.

Authentic Leadership Questionnaire. Historically, Seeman (1960) focused on measuring inauthenticity; he viewed inauthenticity as excessive plasticity of the leader, seeking to comply with perceived demands from public roles. Although Seeman developed a scale for inauthenticity, this scale had questionable construct validity (Walumbwa et al., 2008). In 1983, Henderson and Hoy

revised Seeman's scale and defined the inauthentic leader as someone who is overly compliant with stereotypes and demands related to a leader's role. More recently, Rogers (1959) and Maslow's (1968,1971) studies on the development of a self-actualized person, led to the development of the Authentic Leadership Questionnaire by Avolio, Gardner, and Walumbwa (2004).

The Authentic Leadership Questionnaire (ALQ) is drawn from life experiences, psychological capacities (i.e. hope, self-efficacy), and moral perspectives, and is based on having a greater self-awareness (Wong & Laschinger, 2012). Components of the ALQ include: positive psychological capital (i.e. confidence, optimism, hope, and resiliency as personal resources), positive moral perspective (i.e. ethical/moral values), leader self-awareness (i.e. understanding own talents, strengths, sense of purpose, core values and beliefs), leader self-regulation (i.e. self- control by setting internal standards, and acknowledging expected outcomes), leadership processes/behaviors (i.e. positive role modeling to influence followers), follower self-awareness/regulation (i.e. leaders help followers heighten their self-awareness and values), follower development (i.e. as followers come to know who they are, they will be more transparent with leader), organizational context (i.e. incorporate context into leadership development), veritable and sustained performance beyond expectation (i.e. organization's ability to achieve persistently high performance over time) (Avolio et al., 2004; Luthans & Avolio, 2003).

There are several advantages to the ALQ; for example, it has only has sixteen questions and this tool has also been used in several nursing studies (Eagly, 2005; Giallonardo et al., 2010; Laschinger, et al., 2012; Walumbwa et al., 2010; Wong & Laschinger, 2012). The reliability and validity of the ALQ has also been established (Avolio et al., 2007; Laschinger et al., 2012; Walumbwa et al., 2008; Wong & Laschinger, 2012).

In a cross-sectional study among Chinese supervisors and employees of a Telecom firm (N=387),Walumbwa et al. (2008) reported that the ALQ has both strong convergent and discriminant validity with respect to other leadership constructs. Walumbwa et al. also reported that the ALQ is reliable with Cronbach alpha of 0.091. Furthermore, Walumbwa et al. (2008) found that the estimated internal consistency was at acceptable levels for: self-awareness, .92; relational transparency, .87; internalized moral perspective, .76; and balanced processing, .81.

In summary, while the MLQ has been used in many studies of leadership, it does not specifically measure authentic leadership. Although the ALQ is relatively new, it is a valid and reliable leadership measure. While, the ALQ measures a relatively new concept in leadership, it may provide insight into bullying behaviours in nursing. Therefore, the ALQ was selected for the current study.

Summary

In summary, of this review of the literature, low levels of job satisfaction and high levels of bullying are important issues in nursing; however, minimal research on bullying and job satisfaction has specifically focused on medical-surgical nurses. As well, despite the negative personal and organizational consequences and some efforts to address the issue, workplace bullying still continues to rise. Furthermore, strong evidence reveals that managers are the biggest perpetrators of workplace bullying and are one of the key factors that influence job satisfaction. Therefore, it is time to explore a different influencing factor: authentic leadership. Although authentic leadership may be a relatively new concept, it has been explored in several nursing studies, with promising results related to workplace bullying and job satisfaction, Therefore, sound rationale for the thesis study was established in this review of the literature.

CHAPTER IV: METHODS

The purpose of this chapter is to provide an overview of the methods used in the current study, which includes: the research questions, the research design, setting, sample, instrumentation, procedures, ethical considerations, and data analysis. Moreover, this thesis project was part of a larger study and only the components relevant to this study were discussed.

The Research Questions

The overall purpose of this study was to explore the relationships between job satisfaction, bullying, and authentic leadership among medical-surgical nurses. More specifically, the research questions were:

1. What is the prevalence of bullying among medical-surgical nurses in Manitoba?
2. What is the relationship between workplace bullying and each of the other person and organizational influencing factors?
3. Do medical-surgical nurses in Manitoba perceive their managers to be authentic leaders?
4. What is the relationship between authentic leadership and each of the other person and organizational influencing factors?
5. What is the perceived job satisfaction among medical-surgical nurses in Manitoba?
6. What is the relationship between the person and organizational influencing factors and job satisfaction?
7. What is the relationship between bullying, authentic leadership style and job satisfaction in medical-surgical nurses?

The Research Design

Although job satisfaction has been widely explored in previous research; the relationship between job satisfaction, bullying, and authentic leadership, specific to medical-surgical units has not been studied. Therefore, the purpose of this study was to use the Organizational Framework for Predicting Nurse Retention (OFPNR) to examine the relationship between job satisfaction, bullying, and authentic leadership among medical-surgical nurses. Quantitative research focuses on what proportion of targets think a certain way and qualitative is to know how people think (Sellers, 1998). Therefore, based on the study purpose, a quantitative approach was most appropriate for the current study.

The current quantitative study utilized a non-experimental, descriptive correlational, cross-sectional survey approach. Descriptive correlational designs are used when investigators have reason to suspect a relationship among variables and can justify their ideas though previous research (Brink & Wood, 1998). Additionally, correlational designs normally use research questions rather than hypotheses because this approach supports the nature of the framework (Brink & Wood, 1998). Cross-sectional studies are used to explore one or more variables at a given time. They are useful to determine associations rather than causality, and prevalence, rather than incidence.

Previous research relating to bullying and job satisfaction has been primarily limited to emergency nursing, and critical care nursing, or generically, with no specification of the type of unit. Moreover, leadership studies have mainly focused on transformational/transactional styles of leadership. However, evidence suggests that bullying in nursing is rising; thus, it is time to re-evaluate nurse environments. Therefore, the intent of this study was to focus specifically on medical-surgical nurses and embrace a newly recognized type of leadership: authentic leadership. Thus, a quantitative, cross-sectional design was appropriate, to examine the relationships between job satisfaction, bullying, and authentic leadership among medical-surgical nurses.

The Sample Setting

The Sample

The sample section of this methodology chapter includes the sampling design, and setting, and describes the source and number of participants in the study.

Sampling design. Convenience sampling involves using the most easily accessible people as participants (Polit & Beck, 2012). This sampling strategy may be used when researchers are seeking people with certain characteristics. Convenience sampling is subject to bias because people select themselves as volunteers; nonetheless, this sampling design was an appropriate choice because the population of medical-surgical nurses in Manitoba was of interest for this study.

Statistics Canada (2012) describes probability sampling as every item having an equal chance of being selected, whereas in non-probability sampling, there is only as assumption that there is an even distribution of characteristics within the population. Although, non-probability sampling is less likely than probability sampling to produce a representative sample, most studies in nursing rely on non-probability samples, mainly for the practical reasons of easier to access to the population, and being-less costly and less time consuming. Therefore, non-probability convenience sampling was selected for the current study.

Study sample. The population of interest for the current study included medical-surgical nurses working in the province of Manitoba, which, according to the CRNM included 2061 nurses (personal communication: Kristen Mitchell, Communications Coordinator, CRNM, 27/01/14). Sound rationale for the selection of general duty medical-surgical nurses as the target population have been established. The exclusion criteria included casual nurses and senior management. Participants volunteered to respond to the questionnaire; thus, convenience sampling was utilized.

The Setting

Quantitative research can be conducted in three different types of settings, including: a natural setting, a partially controlled setting, or a highly controlled setting (Burns & Grove, 2003). A natural setting offers no control in a real life setting. It is frequently the setting for descriptive and correlational studies (Burns & Grove, 2003). Therefore, the most appropriate type of setting for the current study was a natural setting. The study took place in the province of Manitoba, Canada, among all RNs working on general medical-surgical units.

In summary, a quantitative approach with non-probable/convenience sampling was an appropriate design for the current study. The sample and setting included nurses working on medical-surgical units in Manitoba.

Study Procedures

Study procedures were initiated following ethical approval from the University of Manitoba's Education and Nursing Research Ethics Board (ENREB). Invitations to Participate (see Appendix A) were e-mailed to all of the eligible general duty medical-surgical nurses in urban hospitals via by the provincial regulatory body for registered nurses (The College of Registered Nurses of Manitoba [CRNM]). The invitations to participate included a link to the: study information, consent form (see Appendix B), and the Fluid survey study questionnaires (see Appendix C). Survey consent was implied by the return of the completed online survey, which was outlined in the study information/consent form. A reminder invitation to participate was sent out by the CRNM 10 days and 21 days after the first email. Incentives to participate included draws for $100 gift certificates. Two winners were drawn one week after the first email, as the early bird prizes and two winners were drawn at the end of the study, receiving one gift certificate card each.

Instrumentation

The instrumentation section describes the particular measures that were employed and how they measure the variables specified in the research questions, within the context of the OFPNR. Instruments were selected to measure each of the variables identified in the research questions: job satisfaction, bullying, and authentic leadership. Additionally, demographic information was elicited to measure the person factors of subjects. Thus, the Medical-Surgical Nurse Retention Survey operationalized the key concepts in this study (see Appendix C, D, E, F, G).

Measuring the Influencing Factors

The Perceived Nurse Working Environment (PNWE) index (see Appendix C) was derived from the Nursing Work Index-Revised (NWI-R; Aiken & Patrician, 2000), which was created from the original Nursing Work Index (NWI). The PNWE index has 42 items and is scored with a 4-point Likert scale ranging from 1=strongly disagree to 4=strongly agree. This instrument measures the nursing organizational climate (Choi et.al., 2004), including nurse/MD collaboration, nursing management, professional practice, staffing & resources, positive scheduling climate, and nursing competence. The PNWE index was selected as the most appropriate tool for the current study because its focus is specific to the nursing organizational climate and has been used in previous studies of critical care nurses (Choi et al., 2004) and ED nurses (Sawatzky & Enns, 2012). Furthermore, this tool conceives the influencing factors of job satisfaction in a similar the manner to how these phenomena are conceptualized in the OFPNR. Finally, the PNWE index can be self-administrated and was therefore appropriate for the e-mail procedure strategy in the current study.

Reliability and validity have been demonstrated for the PNWE index from previous studies. For example, in a large sample of critical care nurses (N=2,324), Choi et al. reported that this instrument was internally stable (Cronbach alpha, .95), with subscales exhibited moderate to high Cronbach alphas ranging from .70 to .91, except for positive scheduling climate (Cronbach alpha;

.56). Furthermore, Content validity, criteria-related validity, and construct validity was demonstrated in previous studies.

The construct validity of the scale was evaluated by comparing the scores for a subsample of nurses in one state employed in magnet and non-magnet hospitals (Choi et al., 2004). Content validity was demonstrated by the fact that magnet hospital characteristics were used as the basis for the development of the NWI-R items (Choi et al., 2004). Criterion-related validity was demonstrated by the ability of the tool to differentiate nurses who worked within a professional practice environment from those who did not, and the ability to identify differences in nurse burnout (Choi et al., 2004).

The PNWE index was the most appropriate choice for the study because it has been used in numerous nursing studies, it is valid and reliable, and can be self-administered easily. Most importantly, this scale captures the essence of factors in the nursing work environment that were central to the current study.

The McCloskey Mueller Satisfaction Scale (MMSS; Mueller & McCloskey, 1990; see Appendix D). One subscale of the MMSS was used to measure control/autonomy. Control/autonomy was included as an influencing factor because of the consistent research evidence of its significance on the nursing work environment and job satisfaction (Kovner et al., 2009; Sawatzky & Enns, 2012; Zangaro and Soeken (2007).

Measuring Bullying

The Negative Acts Questionnaire-Revised (NAQ-R; see Appendix E) was designed to measure workplace bullying and contains items that can be constructed as work-related bullying, person-related bullying, or physical intimidation respectively. The NAQ-R has 22 behavioral questions and one self-labelling question (question #23). However, statistical results from question

23 were not used because it was not relevant to the research questions of this study (personal communication; Brenden Default, Statistician for the University of Manitoba, 03/16/2015). The NAQ-R was the most appropriate choice because it has been used in previous studies, demonstrating acceptable reliability and validity, for example, Chronbach alpha ranging from .89 (Johnson & Rea, 2009) to .92 (Simons, 2008) and content validity was demonstrated (Einarsen et al., 2009).

Scoring of the NAQ-R is accomplished by a sumscore, with scores between 22-32 being categorized as *not bullied; 33-44 = occasionally bullied; ≥45 = severely bullied,* at work (Notelaers, & Einarsen, 2012). Occasionally bullied (i.e., scores between 33-44) shows that respondents are being exposed to a wide range of negative behaviours, even though each individual acts may occur less frequently than weekly and have symptoms of reduced psychological well-being, and may not necessarily need treatment (Bjorkqvist et al., 1994; Einarsen et al., 2011). Scores higher than 45 indicate respondents are exposed to a wide range of negative behaviors, probably on a weekly basis, which are affecting their psychological well-being (Einarsen et al., 2011; Leymann, 1996).

In summary, the NAQ-R was most appropriate for the current study because it has been used frequently in nursing research; it has acceptable reliability and validity; it contains questions that relate to the operational definition of bullying for this study; and it is a relatively short questionnaire; therefore, minimizing participant fatigue.

Measuring Authentic Leadership

The Authentic Leadership Questionnaire (ALQ; see Appendix F) (Avolio, Gardner, & Walumbwa, 2007) was designed to measure authentic leadership. The ALQ has 16 items and is divided into four subscales, including: self-awareness, transparency, ethical/moral, and balanced processing. The ALQ was an appropriate choice for a study of medical-surgical nurses because this instrument has been used in several nursing studies (Giallonardo et al. 2010; Hassan & Ahmed, 2011; Walumbwa et al., 2008; Wong & Lachinger, 2012). As well, acceptable reliability and validity of the

ALQ has been reported in several studies. For example, Walumbwa et al. found that the ALQ had internal consistently ranging from 0.70 to 0.90 and confirmatory factor analysis has supported the validity of the four dimensions: self-awareness, transparency, ethical/moral, and balanced processing. Furthermore, this instrument is most appropriate for the selected population because it has previously been tested on Canadian nurses (Laschinger, et al., 2012; Wong et al., 2010). Another valid reason why this tool was t appropriate for the current study is because authentic leadership was conceptualized in a similar manner to ALQ.

Both deductive and inductive approaches were used for item generation to assess how leaders demonstrate authentic leadership (Hinkin, 1995). Initial content specifications were developed based on: an extensive review of the literature on authentic leadership theory and development and practice, recently completed dissertations on authentic leadership, and discussions with a leadership research group of graduate students focusing on what constitutes authentic leadership. Based on feedback from doctoral students and faculty, and discussion among research team members, four dimensions were identified: self-awareness, relational transparency, balanced information processing, and internalized regulation. Furthermore, the 22 items of the ALQ were subjected to a content validity assessment by faculty members and doctoral students at the same research university, who were asked to assign each item to one of four categories. Six items were not properly classified, thus they were dropped, resulting in a final total of 16 items.

The ALQ is relative short (16 items) and easily self-administered. The ALQ is answered by using a 5-point Likert scale ranging from 0=strongly disagree, 1=disagree, 2=neutral, 3=agree and 4=strongly agree. Scoring is done by the sum the responses on items 1, 5, 9, and 13 (self-awareness), sum the responses on items 2, 6, 10, and 14 (internalized moral perspective), sum the responses on items 3, 7, 11, and 15 (balanced processing), and the sum the responses on items 4, 8, 12, and 16 (relational transparency). Previous researchers reported that individual factors failed to add any

meaningful incremental validity beyond the common core higher factor (Walumbwa et al., 2010; Walumbwa et al., 2008). Therefore, scoring using a mean score for each of the four subscales and composite total mean score approach was used. The scoring is as follows: high authentic leadership scores=2-4 and low=0-1. Scores in the upper range indicate stronger authentic leadership, whereas scores in the lower range indicated weaker authentic leadership (personal communication; Chris Coultas; Customer Consultant; MindGarden Inc., 03/12/2014).

Overall, the ALQ was an appropriate choice because it has been used in other nursing studies; the ALQ is a relatively short questionnaire, with well-established validity and reliability, and measures the concept of interest.

Measuring Job Satisfaction

Job satisfaction was measured by a single item question. This question was based on a Likert 5 point scale (i.e., not at all satisfied to very satisfied; see Appendix G). This single item question is most appropriate when determining the overall satisfaction. Single item questions have been used in previous studies (Lu et al., 2012; Sawatzky & Enns, 2012).

Measuring Person Factors

The Demographic Questionnaire (see Appendix H) was developed based on the review of the related. This demographic questionnaire has been used in a similar study on ED nurses (Sawatzky & Enns, 2012). The person factors include: level of education, current employment status, shift rotation, weekends off per month, current primary employer, current primary area of employment, years of nursing experience, years of experience in medical-surgical units, years of experience in current role, age, gender, marital status, and household income.

Summary

In summary, the instruments selected for this study included: the PNWE, MMSS, NAQ-R, ALQ, and the Demographic Questionnaire. Generally, these instruments demonstrated adequate reliability, and validity, and appeared to measure the concepts of interest in this study; thus, they were appropriate choices for this research.

Ethical Considerations

Ethical guidelines were followed throughout the development, implementation, and evaluation of this study. The study proposal was approved by the Education and Nursing Research Ethics Board (ENREB), prior to initiation of study procedures (see Appendix F: ENREB certificate).

Research ethics requires the protection of dignity of participants, and ensures that the rights and welfare of study subjects are protected (Fouka & Mantzorou, 2011). Included in this section are the ethical considerations related to informed consent, beneficence/ non-malfeasance, respect for anonymity and confidentiality, right to withdraw, deception, feedback/debriefing, and compensation

Informed Consent

Informed consent is an informational process is a document that allows participants to make an informed decision about their participation in a study. An informed consent is an on-going process that starts with the researcher's first contact with the individual and continues until the study is complete or the participant withdraws (Health Canada, 2014). The purpose of an informed consent is to ensure that people are not deceived into participating in research. To give truly informed consent, participants need to understand: the purpose of the research, how long their participation will last, who is involved in the research, the procedures involving participating, possible benefits and risks of participation, how data about them will be managed and used, how long and where the data will be stored, the purpose of the consent form, what is expected of them if they agree to participate in the

research, how information will be provided to them throughout the research, that participation is voluntary, that they can withdraw from the research at any time, without giving any reason, and that the research has been approved by a research ethics committee (Royal College of Nursing Research Society (RCNRS), 2011). Additionally, participants should be given contact details, if they have further questions, and details of the research sponsor (RCNRS, 2011).

Ethical guidelines, as outlined by the ENREB, University of Manitoba were followed. Survey consent was presumed by the return of the completed survey questionnaires. The nature of the study and subjects' participation was clearly outlined in the consent form (see Appendix B). The protocol for ensuring informed consent was included the provision of written information to each potential participant. The informed nature of the consent was ensured via written description of the study. Voluntary participation of subjects in the study was established/reinforced on the consent form. Participants were encouraged to read the consent forms carefully prior to completing the survey and to forward any question or concerns to research team.

Beneficence and Non-malfeasance. These concepts involve the importance of doing effective and significant research, but not to do harm in the process (Beauchamp & Childres, 2001). Beneficence was maintained throughout the study as potential benefits were discussed regarding the possible impact of increased job satisfaction, and decreased bullying in nursing work environments in the future. Anticipated risks with the study were it could stimulate bad experiences with workplace bullying or bad managers, such as post-traumatic stress disorder (PTSD). Therefore, participants were advised if at any time during the completion of the questionnaire, you become upset, please discontinue completing the survey immediately and contact your employee resources department to seek assistance.

Respect for Anonymity and Confidentiality. Anonymity is protected when the subject's identity cannot be linked with personal results (ANA, 1985). Respect for anonymity was ensured because the names were not connected to the results; therefore, any identifying information was kept in a separate file from the results. A third party, the CRNM was contracted to send the questionnaire packages to all practicing general medical-surgical nurses in the province. Thus, information that was sent to e-mail addresses was destroyed after study. Respect for confidentiality refers to the management of private information by the research to protect the participant's identity (Nieswiadomy, 2007). Respect for confidentiality was ensured because all data was kept in a password protected file; any hard copies of information/data were kept in a locked file in the office of the advisor (room 281 HGC); data will be kept for 7 years and then destroyed by confidential shredding.

Right to Withdraw

Participants should always have the right to withdraw from the research process at any time and should not be pressured to stop from withdrawing. Participants were informed that they had the option to not participate if they choose not to, and to withdraw from the study at any time, without consequence.

Deception

Deception refers to the deliberate withholding of essential information or the provision of intentionally misleading information about the research or its purposes. Deception was avoided because all information was as clear as possible with no intent of giving misleading information.

Feedback/Debriefing

Study participants were given the option to receive feedback about the research after they have completed their participation.

Compensation

Although there was no compensation for every study participant, a participant incentive strategy included four $100 dollar gift cards. Two were early bird prizes and two winners were drawn at the end of the study.

In summary, ethical considerations in research are essential to protect the dignity and rights of participants. Participants in the current study were protected from unethical circumstances by ensuring that the basic principles of ethical research processes were upheld.

Data Analysis

Descriptive statistics (i.e., percentages, means, and standard deviations) were used to measure demographic data, prevalence of bullying, perceived leadership, and levels of job satisfaction. Bivariate analysis examines associations/relationships between two variables, strength of relationships, and test hypotheses about relationships between two nominal or ordinal variables (Hassard, 1991). Chi squared test were used to test for possible association between categorical variables (e.g., gender, education, marital status). Furthermore, bivariate analysis were used in this study as well, more specifically, Kruskal-Wallis was used to compare medians of the continuous variables (e.g. bullying and organizational factors). A Kruskal-Wallis test was used to test the correlation between the behavioral component and self-labelling component of the NAQ-R. The Spearman Correlation Coefficient was used to measure the strength of the relationship between two variables (e.g. authentic leadership and influencing factors).

Regression models were used to assess the effects of influencing factors on the outcome variable of job satisfaction and influencing factors on bullying. These models produced adjusted estimates of interrelationships and thereby allowed us to determine which variables were significantly influential on job satisfaction. In this study, regression analysis was performed on only the significant influencing variables, with the rationale that including too many of the variables can cause inaccuracy among the significant variables (personal communication, Brenden Default, March 05, 2015). Multivariate regression analyses were conducted with job satisfaction and bullying as the outcome variables. The level of significance chosen for this study is 0.05.

Summary

In summary, this chapter presented the research questions, and described the research design; A quantitative design with a cross-sectional survey approach was utilized. A convenience sample of the target population of medical-surgical nurses in Manitoba was elicited by a mail out invitation sent by the CRNM. Instrumentation included the operationalization of the key study concepts, to include valid and reliable measures. Lastly, data analysis was discussed, with descriptive statistics, bivariate tests, and multivariate ordinal regression analysis being utilized to answer the research questions.

CHAPTER V: RESULTS

This chapter presents the findings from the thesis component of the larger Manitoba Medical-Surgical Nurse Retention Study. The overall findings discussed are related to examining if there is a relationship between job satisfaction, bullying, and a manager's leadership style among medical-surgical nurses. More specifically, the research questions were:

1. What is the prevalence of bullying among medical-surgical nurses in Manitoba?
2. What is the relationship between workplace bullying and each of the other person and organizational influencing factors?
3. Do medical-surgical nurses in Manitoba perceive their managers to be authentic leaders?
4. What is the relationship between authentic leadership and each of the other person and organizational influencing factors?
5. What is the job satisfaction status among medical-surgical nurses in Manitoba?
6. What is the relationship between the person and organizational influencing factors and job satisfaction?
7. What is the relationship between bullying, authentic leadership style and job satisfaction in medical-surgical nurses?

Data collection occurred over a four week period from September 12, 2014 to October 10, 2014. Questionnaires were entered into an internet program called Fluid Surveys. The data from the 294 completed surveys were transferred to an excel spreadsheet, then exported to SPSS (computer program). The initial data cleaning and coding procedures, and statistical analysis were completed with the guidance and support of a statistician from the MCHNR. Data analyses procedures undertaken to address the research questions were in the previous chapter.

Demographic Data

This section describes the demographic data, as displayed in Table 1. Three hundred and seventeen nurses (N=317) participated in this study. In 2014, 2061 Manitoba RNs indicated medical-surgical as their area of nursing (personal communication: Kristen Mitchell, Communications Coordinator, CRNM, 27/01/14). Therefore, the response rate for this study was 15%. The study participants ranged from 23 to 65 of age, with a mean age of 37.9 years old. With the largest group (n=80) being between 30 to 35 (i.e., born between 1980-1985). The majority of the participants that filled out the survey were female (93%) and married or living common law (66%). Furthermore, the majority of participants (31%) had an overall household income of $75, 000 to $100,000. While 59% of the participants reported having an undergraduate degree (i.e., BN, BScN; 59%), 36% reportedly had a RN-diploma.

On average, the participants had 6.1 years of experience in their current role, 10.6 years of medical-surgical experience, and 12.71 years of nursing experience. One hundred and eighteen nurses (37% of the sample) had 5 or less years of nursing experience and 170 nurses (54% of the sample) had less than 5 years of experience in their current role. Not surprisingly, most of the participants that filled out the survey (48%) were employed in one of the province's two tertiary hospitals (i.e. HSC or SBH; 48%) and worked on a medical or surgical units, as opposed to other/combined units (75%). While approximately, 50% of the participants reported working part time as staff nurses, the majority also worked a rotating 12 hour day/night rotation (43%) and on average had 2 weekends off a month (69%).

Table 1. *Sample Description: Person Factors (N = 317)*

Factor	**#/mean**	**%/SD**
Age	Mean = 37.9; median=35 (range = 23-65)	SD=11.59
Gender:		

Female	262	92.9%
Male	20	7.1%
Marital Status		
Single	73	25.7%
Married	189	66.5%
Other	22	7.7%
Household Income		
<$50,000	13	4.7%
$50,001-$100,000	157	57.1%
$100,001-$150,000	75	27.3%
>$150,000	30	11.0%
Education		
Diploma	103	36%
Degree (e.g., BN)	168	58.7%
other	15	5.2%
# of years in nursing	Mean=12.71; median=7 (range=0.83-45)	SD=11.77
# of years in Medical/surgical nursing	Mean=10.94; median=6 (range=1-43)	SD=10.74
# of years in current role	Mean=6.91; median=4 (range=0-43)	SD=7.90
Employer		
Tertiary hospital	137	47.6%
Urban/community hospital	103	35.8%

Rural hospital	41	16.3%
Other	1	3%
Area of employment		
Medical unit	92	32.1%
Surgical unit	124	43.2%
Combined medical-surgical	35	12.2%
Other	36	12.5%
Employment status		
Staff nurse – part-time	142	49.5%
Staff nurse – full-time	96	33.4%
Clinical resource nurse	30	10.5%
other	18	6.3%
Shift rotation		
8 hour days only	29	10.1%
Rotating 8 hr days/evenings	44	15.4%
Rotating 8 hr days/nights	35	12.2%
Rotating 12 hr Days/nights	124	43.4%
Permanent evenings or nights	27	9.4%
Other	27	9.4%
# of weekends have off/month		
≤ 1	18	6.3%
2	199	69.3%
3	32	11.1%
4	38	13.2%

*Note: actual number of responses ranged from n=282-288; SD=Standard Deviation

Analysis of Research Questions

Research Question #1. *What is the prevalence of bullying among medical-surgical nurses in Manitoba?*

This question was addressed by using the behavioral component of the NAQ-R. These results indicated that the majority of the study participants did not perceive themselves as bullied (57%), However, an alarming 43% of nurses had reportedly been bullied (occasionally/severely at work).

Table 2 *Bullying: Frequency Distribution (N=291*)

Rank	**n**	**%**
1. Not Bullied (22-32)	166	55.31%
2. Occasionally Bullied (33-44)	80	28.57%
3. Severely Bullied (45 plus)	45	16.12%

Note: Frequency Missing=26

Research Question 2# *What is the relationship between workplace bullying and each of the influencing factors in medical-surgical nurses?*

This question was addressed by comparing the influencing factors: person factors, organizational factors, and authentic leadership to workplace bullying with bivariate and multiple regression analyses. Analysis of the scores from PWNE scale, NAQ, demographic questionnaire, and ALQ provided the data to answer this question.

a. What is the relationship between the person and organizational influencing factors and bullying?

There were no significant associations between bullying and the person factors. Table 3 lists the results of the significant associations between the organizational variables and bullying. Eight of the 22 organizational variables were significantly ($p<.05$) associated with workplace bullying: professional practice, staffing and resources, management, nurse/MD collaboration, positive scheduling, competence, control/autonomy, and authentic leadership (total and subscales).

Table 3 *Association Between Organizational Influencing Variables and Bullying Using Kruskal-Wallis test (n=273)*

Variable	**Not Bullied (M)**	**Occasionally Bullied (M)**	**Severely Bullied (M)**	**P-Value**
Professional Practice	36.89	33.18	31.18	<.0001
Staffing Resources	11.98	10.30	09.69	<.0001
Management	14.46	11.81	11.04	<.0001
Nurse/MD Collaboration	12.47	11.24	11.69	0.0013
Positive Scheduling	06.62	06.10	05.64	0.0140
Competence	19.30	17.25	16.60	<.0001
Control/autonomy*	15.50	18.79	20.45	-<.0001

Note: M=mean; *high control/autonomy scores = low control/autonomy

b. What is the relationship between perceived authentic leadership and bullying?

This question was addressed by analyzing responses on the NAQ-R and Authentic ALQ. Authentic leadership (total score) was significantly inversely related to bullying; that is, the more bullied the participants, the less likely they were to perceive their managers as authentic leaders. The severely bullied participants perceived their managers to more likely be lowest in self-awareness, compared to the other subscales. Table 4 lists the results of Kruskal-Wallis test on the associations between the authentic leadership and bullying.

Table 4 *Association Between Authentic Leadership and Bullying Using Kruskal-Wallis test (N=273)*

Variable	Not Bullied (M)	Occasionally Bullied (M)	Severely Bullied (M)	P-Value
Transparency subscale	2.84	2.03	1.96	<.0001
Moral/Ethical subscale	2.80	2.12	1.98	<.0001
Balanced Processing subscale	2.62	1.81	1.75	<.0001
Self-awareness subscale	2.53	1.71	1.50	<.0001
Authentic Leadership Total	2.71	1.93	1.79	<.0001

*Note: M=mean

c. Multivariate analysis of the relationship between bullying & organizational factors?

Table 5 presents the findings from the Multivariate Ordinal Regression model with bullying as the outcome variable. This multivariate analysis demonstrates a significant relationship between bullying and the PNWE (i.e., organizational factors) and ALQ (authentic leadership). Thus, generally the organizational factors, including: MD/nurse collaboration, management, professional practice, staffing and resources, positive scheduling climate, and competence were significantly related to bullying. Thus, the higher the PNWE and ALQ score, the lower the odds of being in a high-bullying category. The lower the control/autonomy, the higher the odds of being in a high-bullying category.

Table 5 *Multivariate Ordinal Regression Model: Bullying*

Variable	Odds Ratio	95% Wald Confidence Limits		P
PNWE total	0.968	0.942	0.995	0.0187
ALQ total	0.979	0.960	0.998	0.0278

Control/autonomy	0.912	0.848	0.982	0.0139

Research Question #3 *Do nurses perceive their managers to be authentic leaders?*

This question was addressed by using the Authentic Leadership Questionnaire (ALQ) to measure perceived leadership. Based on the ALQ, authentic leadership scores in the upper range (i.e., 2-4) indicate stronger authentic leadership, whereas scores in the lower range (i.e., 0-1) indicated weaker authentic leadership (personal communication: Chris Coultas, Mind Garden Inc, 11/25/2014). On average, the participants perceived their managers to be high in all four subscales, with Transparency (mean=2.47) and Moral/Ethical (mean=2.47) rated as the highest, followed by Balanced Processing (mean=2.24), and self-awareness (2.13), with a total average authentic leadership score of 2.34, as demonstrated in the Table 6. Thus, on average the participants rated their managers high on authentic leadership.

Table 6 *Authentic Leadership: Frequency Distribution*

Factor	**M**	**SD**
Transparency	2.47	5.24
Moral/Ethical	2.47	4.08
Balanced Processing	2.24	3.30
Self-awareness	2.13	4.70
Total ALQ score	2.34	16.28

SD=standard deviation, M=mean
Note: high authentic leadership=2-4, low authentic leadership=0-1

Research Question # 4. What is the relationship between authentic leadership and the influencing factors?

This question was addressed by exploring the association between the person and organizational influencing factors and authentic leadership. Analysis of the scores from the PWNE scale, NAQ-R, demographic questionnaire, and ALQ provided data to answer this question. Thirteen (including bullying) of the 20 influencing factors were significantly related to authentic leadership. Table 7 highlights the results of Spearman's Correlation analysis of the continuous variables and authentic leadership. Of the person factors, age had the highest correlation, followed by years of experience in current role. Thus, younger nurses perceive their managers to be more authentic than older nurses. Management had the highest correlation with authentic leadership, followed by professional practice.

Table 7 *Correlation Matrix: Association Between Influencing Variables and Authentic Leadership Using Spearman's Correlation Coefficient*

factors	PP	SR	Mgmt	MD/N	PS	Comp	C/A	age	y/n	y/m-s	y/c/r
Transparency	0.515*	0.272*	0.763*	0.246*	0.228*	0.359*	-0.432*				
Moral/ ethical	0.476*	0.291*	0.697*	0.253*	0.149*	0.330*	-0.437*				
B.P.	0.550*	0.285*	0.716*	0.187*	0.182*	0.348*	-0.439*				
S.A.	0.562*	0.308*	0.740*	0.197*	0.203*	0.350*	-0.489*				
Total ALQ Score	0.549*	0.303*	0.770*	0.237**	0.208*	0.367*	-0.473*	-0.779**	-0.438**	-0.539**	-0.638**

Note: control/autonomy scores are reversed: high control/autonomy scores = low control/autonomy
Note: $p<0.0001$=*, **=$p<-.05$
B.P.=balanced processing; S.A.= self-awareness; PP= professional practice; SR= staffing and resources; Mgmt= management; PS= positive scheduling climate; C/A= control/autonomy; ALQ= authentic leadership total score; Age= age; y/n= years of nursing experience; y/m-s= years of experience in medical-surgical nursing; y/c/r= years of experience in current role

Table 8 outlines the responses to Kruskal-Wallis test analysis of the association between the non-continuous person influencing variables and authentic leadership. Of the person factors, only gender was significant. Male participants perceived their managers to be more authentic than females, rating their manager as higher in all the subscales, with ethical/moral being the highest. All subscales were significant except for self-awareness.

Table 8 *Association Between Non-Continuous Person Influencing Variables and Authentic Leadership (total score) Using Kruskal-Wallis tests*

Factor	**Transparency (M)**	**Balanced Processing (M)**	**Ethical/moral (M)**	**Self-awareness (M)**	**Total (M)**
Gender:					
Male	2.91*	2.68*	2.95*	2.58	2.91*
female	2.45*	2.23*	2.47*	2.10	2.45*

*Note: actual number of responses ranged from n=265-287, m=mean, p=.<.05

Research Question #5. *What is the job satisfaction of medical-surgical nurses in Manitoba?*

Participants were asked to rate their overall job satisfaction on a five point Likert scale. Table 9 presents the frequency distribution of the responses. These results showed that 65% of the participants reportedly had overall job satisfaction (i.e., satisfied/very satisfied), compared to 21% who had job dissatisfaction (i.e., dissatisfied/very dissatisfied) and 14% who were neutral.

Table 9 *Job Satisfaction: Frequency Distribution (N=287)*

Rank	**n**	**%**

1 Not at all Satisfied	8	2.97
2 Somewhat Dissatisfied	54	18.22
3 Neutral	40	14.13
4 Satisfied	150	53.16
5 Very Satisfied	35	11.52
Total	287	100

Note: Frequency Missing=30

Research Question #6 What is the relationship between person and organizational influencing factors and job satisfaction?

This question was addressed by exploring the relationship between the influencing person and organizational factors, including: workplace bullying, and authentic leadership, and job satisfaction. Bivariate and multiple regression analyses of the scores from the PWNE scale, NAQ-R, the demographic questionnaire, and ALQ provided data to answer this question.

a. *What is the relationship between job satisfaction and the person & organizational influencing factors?*

The results of Chi-square analysis of the relationship between the discrete influencing factors and job satisfaction are presented in Tables 10. Table 11 presents the results of the associations between the continuous influencing factors. Only one significant relationship was found between job satisfaction and person factors (e.g., gender). However, area of employment was approaching statistical significance ($p<.055$). Nurses on surgical units were the most satisfied and nurses are medical units were the least satisfied. There were significant relationships between job satisfaction

and organizational factors, included: professional practice, nurse/nurse and nurse/MD collaboration, management, staffing and resources, control/autonomy, and competency.

Table 10 *Associations Between Person Influencing Variables and Job Satisfaction using Chi-Square test (N=299)*

Variable	Very Dissatisfied (%)	Dissatisfied (%)	Neutral (%)	Satisfied (%)	Very Satisfied (%)	P
Gender*						.0278
Female	10	0	10	60	20	
Male	2.30	20.31	14.56	50.96	11.88	
Education						.1516
Diploma	0	2157	11.76	52.94	13.73	
Degree (e.g., BN)	4.17	19.05	15.48	51.19	10.12	
other	6.67	0	13.33	53.33	26.67	
Employment status						.2686
Staff nurse – part-time	2.82	17.61	17.61	54.23	7.75	
Staff nurse – full-time	3.16	14.74	12.63	52.63	16.84	
Clinical resource nurse	3.33	30.00	3.33	50.00	13.33	
other	0	27.78	11.11	38.89	22.22	
Shift rotation						.1234
8 hour days only	0	24.14	3.45	44.83	27.59	
Rotating 8 hr days/evenings	6.93	16.28	9.30	62.79	4.65	
Rotating 8 hr days/nights	2.86	8.57	22.86	51.43	14.29	
Rotating 12 hr Days/nights	1.61	18.55	16.94	51.61	11.29	
Permanent evenings or nights	7.41	25.93	7.41	44.44	14.81	
Other	0	22.22	11.11	59.26	7.41	

# of weekends have off/month						.1226
≤ 1	0	16.67	5.56	77.78	0	
2	4.04	16.16	14.65	54.04	11.11	
3	0	21.88	25	34.38	18.75	
4	0	31.58	2.63	47.37	18.42	
Employer						.2183
Tertiary hospital	4.41	18.38	9.56	55.88	11.76	
Urban/community hospital	1.94	20.39	19.42	49.51	8.74	
Rural hospital	0	17.02	14.89	48.94	19.15	
Area of employment						.055
Medical unit	6.90	21.84	17.24	43.68	10.34	
Surgical unit	1.71	11.97	12.82	61.54	11.97	
Combined med/other	0	23.44	12.50	51.50	12.50	
Marital Status						.4527
Single	2.74	21.92	16.44	53.42	5.48	
Married	3.19	17.55	12.77	51.06	15.43	
Other	0	18.18	13.64	63.64	4.55	
Household Income						.2535
< $50,000	0	30.77	30.77	30.77	7.69	
$50,001 - $100,000	6.12	40.19	31.25	105.05	17.39	
$100,001-$150,000	5.33	29.16	24.18	104.05	37.27	
>$150,000	3.33	20	3.33	66.67	6.67	

*Note: actual number of responses ranged from n=268-286, m=mean; *p<.05; missing=30

Table 11 *Association Between Continuous Person and Organizational Influencing Variables and Job Satisfaction Using Kruskal-Wallis test (N=299)*

Variable	Very Dissatisfied (M)	Dissatisfied (M)	Neutral (M)	Satisfied (M)	Very Satisfied (M)	P Value
Person Factors						
Age		37.65	37.12	38.06		0.9364
# years nursing	4.69	14.13	11.60	13.17	16.74	0.2018
#years in med/surg.	4.56	13.04	9.40	11.20	14.54	0.1396
#years in current role	4.06	7.28	7.38	6.81	10.06	0.6230
Org. Factors						
Professional Practice	31.50	30.67	34.88	35.77	39.23	<.0001
Nurse/MD Collaboration	12.00	10.89	11.86	12.05	13.74	<.0001
Positive Scheduling	5.5	5.96	6.15	6.55	6.43	0.2673
Competence	16.00	16.81	18.00	18.53	20.60	<.0001
Control/Autonomy*	20.25	21.33	18.63	16.21	11.89	-<.0001
Authentic Leadership (total)	38.13	44.16	50.97	55.80	64.90	<.0001

Note: m=mean, missing=30, *high control/autonomy scores = low control/autonomy

b. *What is the relationship between job satisfaction and bullying?*

Table 12 demonstrates the significant relationship between bullying and job satisfaction, using a Kruskal-Wallis test. Thus, the less participants were bullied, the more likely they were to be satisfied in their workplaces.

Table 12 *Associations Between Job Satisfaction and Bullying Using Kruskal-Wallis test (N=269)*

Rank	Not Satisfied (M)	Neutral (M)	Satisfied (M)	P-Value

Not Bullied (22-32)	08.05	14.77	77.18	<.0001
Occasionally bullied (33-44)	34.62	11.54	53.85	<.0001
Severely Bullied (45 plus)	42.86	16.67	40.40	<.0001

Note: M=mean, missing: 30

c. What is the relationship between job satisfaction and authentic leadership?

This question was addressed by analyzing responses on the ALQ and job satisfaction. Table 13 presents the results of Kruskal-Wallis test on the associations between the ALQ variables and job satisfaction. Authentic leadership (total score) was significantly related to job satisfaction. In other words, the more satisfied participants were, the more likely they would perceive their managers as authentic. Also, in participants who were reportedly most satisfied with their jobs, transparency scores were higher than the other subscales.

Table 13 *Association Between Job Satisfaction and Authentic Leadership (n=269)*

Variable	Very Dissatisfied (M)	Dissatisfied (M)	Neutral (M)	Satisfied (M)	Very Satisfied (M)	P-Value
Authentic leadership (Total score)	1.38	1.76	2.19	2.49	3.06	<.0001
Transparency	1.58	1.88	2.4	2.57	3.32	<.0001
Moral /Ethical	1.63	1.99	2.29	2.62	3.14	<.0001
Balanced Processing	1.17	1.72	2	2.42	2.88	<.0001
Self-awareness	1.06	1.41	1.96	2.31	2.92	<.0001

Research question #7. What is the relationship between bullying, authentic leadership style and job satisfaction in medical-surgical nurses?

Table 14 presents the findings of the multivariate ordinal regression analysis of job satisfaction. There was a significant relationship between job satisfaction and control/autonomy. Although, authentic leadership, PNWE, and bullying were significant in the bivariate analyses, these variables were not significant in this multivariate analysis, however, bullying was approaching statistical significance (p=.06) and area of employment was also significant.

Table 14 *Multivariate Ordinal Regression Model: Job Satisfaction*

Variable	**Odds Ratio**	**95% Wald confidence Limits**	**P**
PNWE total	0.977	0.946-1.009	0.1530
Control/autonomy	0.827	0.757-0.904	<.0001
ALQ total	0.990	0.969-1.013	0.3932
Gender	0.631	0.160 -2.486	0.5106
Bullying			0.0608
Severely *vs* Occasionally	0.460	0.202-1.045	
Not Bullied vs Severely	0.946	0.420-2.133	
Area employment			0.0043
Medical vs Surgical	2.858	1.462-5.587	
Other vs combined	1.078	0.507-2.293	

Summary

This chapter reported the findings related to the research questions of this study. Various bivariate, and multivariate regression statistical tests were used to address the overall purpose of this study, which was to explore if there is a relationship between job satisfaction, bullying, and perceived manager's leadership style among medical-surgical nurses.

Descriptive statistics were used to address demographic data, with the majority of participants being between the age of 30-35. Although there were no significant associations between bullying and person factors, bullying was significantly inversely related to all of the organizational factors, including authentic leadership; bullying was also inversely related to job satisfaction. Moreover, a multivariate regression model with bullying as the outcome, indicated a significant relationship between bullying and authentic leadership, control/autonomy, and the organizational factors. Moreover, the Spearman Correlation Coefficient analysis demonstrated that management had the highest correlation with authentic leadership. Furthermore, a multivariate regression model with job satisfaction as the outcome, indicated a significant relationship between job satisfaction and control/autonomy and surgical units being the most satisfied. These study findings highlight the significant inter-relationships between the three central study concept of bullying, authentic leadership and job satisfaction. These findings will be discussed in the next chapter.

CHAPTER VI: DISCUSSION

The purpose of this chapter will be to analyze and discuss the study results within the context of previous research. This section will use the conceptual framework as a guide to address the research questions of this study. Thus, demographics and organizational factors will be discussed according to the study's main concepts of: workplace bullying, authentic leadership and job satisfaction. Furthermore, study limitations, and implications for nursing, and future research, will be included in this chapter.

Demographic Results

This section will provide a summary of the demographics of this study's participants. Many demographic statistics specific to Manitoba nurses were not available; thus, this information was obtained from the Canadian Nurses Association (CNA; 2010), Statistics Canada, and the College of Registered Nurses of Manitoba (CRNM, personal communication, February 9, 2015).

The proportion of female to male nurses in this study (92.9% women and 7.1% for men) was similar to the CNA (93.6% women and 6.4% for men; 2010). Moreover, ages of the study respondents (mean age=37.9), were similar to the average medical-surgical RN in Manitoba (mean age= 36.7; CRNM, 2015). However, when the age distribution was examined more closely, it was noted that participants who were born between 1985-1990 (i.e., 25-30 years of age) were the largest age cohort (n=77 of 294 or 26%). Rationale for younger nurses participating in this study may be related to the fact that this study was an online survey and younger nurses may have more experience with online surveys. A second rationale may be that this was a workplace bullying survey and literature reports that younger nurses are most often bullied compared to older nurses (Griffin, 2004; Kamchuchat et al., 2008; Pai & Lee, 2011; Rodwell & Demir, 2012; Yildirim, 2009); thus, this

survey would likely appeal more to them than the older nurses who are not bullied, or may, in fact, be the bullies.

Interestingly, educational level among the study participants was the reverse of the Canadian average. In this study 58.7% of medical-surgical RNs reportedly had a degree, where-as the Canadian average was 38.8%. Conversely, thirty-six percent of study participants had a diploma compared to the Canadian average 57.6% (CNA, 2012). The difference may be related to sampling bias, in that younger nurses are more likely to have a degree. The rationale for younger nurses having degrees is related to changes in educational requirements over the past several decades. In 2004, Statistics Canada (2004) reported that most provinces had announced that the minimum nursing educational requirements would be a four-year baccalaureate degree. In Manitoba, baccalaureate entry to practice was initiated in 2010 (CRNM, February 18, 2015; personal communication).

Equivalent full time (EFT) status between the study participants and the Canadian average was also reversed. According to the CNA (2012), on average 58% of Canadian nurses worked full time as compared to 33.4% of the study participants. This rationale may also be related to sampling bias as many younger nurses choose to work part time. Previous research reports that 82% of RNs voluntarily work part time (Statistics Canada, 2004). Furthermore, research has reported that generation Y (born starting in the 1980s) prefer more of a work/life balance (Lower, 2007); however, there is minimal research to support younger nurses preferring part time.

Most participants worked every other weekend, 12 hour shifts, on surgical units, and in tertiary hospitals. These results were not surprising because most nurses who met the inclusion criteria, i.e., general duty nurses, work every other weekend. Furthermore, most nurses work 12 hour shifts. Previous literature has supported that younger nurses prefer 12 hour shifts; however, older

nurses find it too tiring. Finally, the two tertiary hospitals employ the majority of nurses in the province.

In summary, based on the demographic data, overall, the participants of this study were younger, more educated, and more likely to work part time, then the average Canadian nurse. The reasons for these demographic differences may be because younger nurses are more likely to fill out online surveys, and because the survey was about bullying. These insights into the demographics of the study sample will facilitate the following discussion related to bullying, authentic leadership, and job satisfaction.

Workplace Bullying

This section will focus on the study results of workplace bullying, within the context of the associated literature. The research questions addressed the prevalence of bullying and the relationships between bullying and authentic leadership and each of the other person and organizational influencing factors, as well as job satisfaction. These questions were analyzed with bivariate and multivariate analysis.

A significant correlation was found between the behavioral component and self-labelling component of the NAQ-R. The study results indicated that the majority of medical-surgical nurses perceived themselves *as not at all bullied* (55%); however, an alarming 45% of nurses were bullied (occasionally/severely bullied) at work. One hundred and sixty-six respondents reportedly were not bullied, eighty respondents were occasionally bullied, and forty-five were severely bullied. The bullying findings from this study were similar to previous literature. According to the CNA (2011), 44% of female nurses and 50% of male nurses reportedly had been exposed to hostility from people with whom they work**.** Although some of the statistics are higher, this may be related to the specific population targeted or sampling techniques. For example, Lewis (2006) found that 80% of nurses

will experience bullying in their careers. However, much of the literature does not indicate a specific unit type; therefore, this study contributes novel evidence related to bullying in medical/surgical nurses.

These findings are also significant because according to previous research being occasionally bullied shows that respondents are being exposed to a wide range of negative behaviours, even though each individual acts may occur less frequently than weekly and have symptoms of reduced psychological well-being, and may not necessarily need treatment (Bjorkqvist et al., 1994; Einarsen et al., 2011). Scores in the severely bullied range indicate respondents have been exposed to a wide range of negative behaviors, probably on a weekly basis, which is affecting their psychological well-being and may possibly need treatment (Einarsen et al., 2011; Leymann, 1996).

Bullying and Person Factors

None of the person factors in this study were -significantly related to bullying. The non-significance of age and bullying is inconsistent with most bullying research. For example, although a few studies have found no significant relationship between age and bullying (Quine, 2001; Vartia, 1996), the majority of literature in this area demonstrates that younger nurses are more likely to be bullied than older nurses (Clendon & Walkder, 2012; Griffin, 2004; Kamchuchat et al., 2008; Pai & Lee, 2011; Rodwell & Demir, 2012; Yildirim, 2009). A rationale for why bullying and age were not significant in this study may be related to skewed data with a few much older nurses and mainly younger nurses, but not many in between. For example, five nurses were born between 1941 and 1949 and eighty were born between 1985-1990. Thus, there is a 49 year age gap between the oldest nurse and youngest nurse. Years of nursing experience, years on medical-surgical units, and years in current role had a similar skewed distribution. Thus, although the sample was mainly made of nurses with less 5 or less years of nursing experience (n=118), rationale for skewed results may be related to

the 17 nurses that had 36 plus years of experience. Similarly, 170 nurses had less than 5 years in their current role and 22 nurses had over 21 years of experience in their current role. Another rationale for the non-significance of these person factors and bullying maybe that bullying is predominately an organizational issue, rather than demographically related. For example, Lewis (2006) concluded that bullying maybe more related to a learned behavior in a workplace, than related to any psychological variables.

Similar to previous research, a number of studies have concluded that there is no relationship between education and bullying behaviors (Kamchuchat et al., 2008; Pai & Lee, 2011; Salim et al., 2002). Furthermore, while unit type was non-significant, all units in this study were medical-surgical units, which are generally quite similar. Previous research had mixed findings as to which units had the most bullying. The reason could be related to the fact that very few studies specify the type of unit (Pai & Lee, 2011). Overall, person factor findings in this study were not significant, which except for age, is similar to the literature that reports mixed findings between person factors and bullying.

Bullying and Organizational Factors

Bivariate analyses demonstrated significant associations between workplace bullying and several of the organizational factors, including: authentic leadership, nurse/nurse and nurse/MD collaboration, nursing management, professional practice, control/autonomy, staffing and resources, positive scheduling, and competence. These findings are generally consistent with previous research.

Authentic leadership. In the bivariate analysis, there was a significant inverse relationship between bullying and authentic leadership. In other words, the more bullied participants were, less likely to perceive their managers as authentic leaders. The most severely bullied participants perceived their managers to be lowest in self-awareness, compared to the other subscales. Although

authentic leadership is a relatively new concept, and there has been minimal research on this type of leadership, nonetheless, several previous studies have reported a significant inverse relationship between workplace bullying and authentic leadership (Frederick, 2014; Lashchinger & Fida, 2014; Laschinger et al., 2012).

These findings may be related to managers who possess the authentic leadership characteristics being more capable of dealing with workplace conflict. Authentic leadership is distinguished as being different from other types of leadership e.g. transformational leadership, mainly because of the self-awareness component. Thus, a manager who is dealing with bullying must be aware of what bullying is and what it is not, as it is well known as "hidden violence." Being aware that conflict is a normal aspect of everyday work life but distinguishing between conflict and bullying takes a greater understanding of indirect tactics that bullies often use. Normal conflict is occasional, not pre-planned, in the heat of the moment, genuine upset to both parties, trying to work things out, no trying to take something from someone, both parties admit some responsibility, and effort to solve the problem by both parties (Olweus, 1993). On the other hand, bullying includes: repeated happening, premeditated, on purpose, intentional, planned, person being bullied is more upset, trying to be the one in control, want to take power or possessions from someone, blame is laid on the person who is bullied, and no effort to solve the problem by the person bullying (Olweus, 1993). Being aware of how to identify bullying is essential to addressing it. Moreover, being self-aware of how one can impact the environment and also understanding how others impact the environment is central to authentic leadership.

Another component to authentic leadership is transparency, which involves sharing one's true feelings and thoughts; thus, building a trustful and respectful relationships with staff. This is important because respect from a manager is a main reason people stay in an organization (Ulrich et al., 2005). The ethical/moral component of authentic leadership involves been guided by internal

moral values, and that behavior is consistent with words (Avolio et al., 2007). Furthermore, balanced processing, which is described as someone who gathers all information, before making decisions, is critical when dealing with conflict because of the ability to understand the positive and negative viewpoints. Overall, the components of authentic leadership provide insight into why there was a significant inverse relationship between bullying and authentic leadership in this study.

Nurse/physician collaboration. Nurse/physician collaboration includes communication between nurses and between nurses and physicians (Choi et al., 2004). In the bivariate analysis, there was a significant association between bullying and nurse/MD collaboration ($p<.0028$). Although there is still some controversy as to who the biggest bullies are, nonetheless, the majority of the literature indicates that poor team collaboration is a positive predictor of bullying behaviors (Adams, 1992; Einarsen et al., 1994; Hoel & Cooper, 2000; Leymann, 1993; Zapf et al., 1995).

The findings of a significant inverse association between bullying and nurse/nurse and nurse/physician collaboration in this study are similar to the research literature in this area. However, the rationale for this finding in the current study may simply be related to the study sample. For example, Johnson and Kring (2012) found that 54% of medical-surgical nurses reported that physicians do not communicate well with nurses, compared to 43% of intensive care unit nurses who reported physicians do not communicate well with nurses. This could be related to lack of interdisciplinary activities on medical-surgical units, compared to other areas, such as the daily multidisciplinary rounds that occur on intensive care units. Another possible rationale may be related to younger nurses on medical-surgical units being less likely to be assertive than more experienced nurses. The lack of assertiveness in younger nurses has been connected to perceived power imbalances (Nelson, et al., 2008). The literature also reports that nurses with more experience were more likely to report better collaboration with physicians (Nelson, et al., 2008), which may explain the findings related to the sample of relatively young nurses in the current study.

Finally, the association between nurse to nurse collaboration and bullying may be related to the dependency that less experienced nurses have on more senior staff for guidance, especially, on medical-surgical units where new nurses commonly begin their nursing career. Senior staff hold a lot of power and influence over the guidance of newer nurses; thus, team collaboration is essential for a junior nurse's survival; however, senior nurses on medical-surgical units may become exhausted or overwhelmed with constant mentoring of new staff (Dziedzic, 2010; Kemper, 2007; Yonge, et al., 2002).

In summary, many of these findings regarding nurse/nurse collaboration and nurse/MD collaboration can be related to the sample of relatively younger nurses. Poor team collaboration can arise from poor communication, due to a lack of assertiveness in confrontation with physicians, which can be perceived as bullying. Furthermore, younger nurses need more guidance and this may overwhelm senior nurses, who may already be overworked, which in turn may lead to bullying.

Nursing management. In the bivariate analysis, there was a significant inverse relationship between bullying and management ($p<.0001$). The majority of the literature reports that managers are the biggest perpetrators of bullying in nursing (Cleary et al., 2010; Hoel & Cooper, 2000; Johnston et al. 2009; Johnson & Rea, 2009; Lewis, 2000; Quine, 2001; Rayner, 1997; Thobaben, 2011; Ulrich et al., 2005).

The association between management and bullying may be related to lack of support, praise, recognition, and respect nurses receive. The literature concurs that more respect from managers would be likely to cause nursing staff to reconsider leaving their current position (Ulrich et al., 2005). Furthermore, nurses on medical-surgical units tend to be less experienced and younger; thus, there is more need for encouragement and support especially during their first years of practice, which may

explain the findings of this study, as the sample was generally younger nurses who likely need more support from managers.

The association between management and bullying may also be related to other influencing factors, including team collaboration, professional practice, control/autonomy, resources/staffing, scheduling, and nursing competency. Nurse managers have a considerable amount of influence and control over the nurse's work environment; thus, this association may simply be related to a power imbalance. Less experienced nurses not only lack nursing experience, but may lack conflict resolution experience and not knowing how to handle or report bullying situations. For example, disrespectful relationships with senior nurses or physicians can affect bullying levels, if management does not identify or address these issues. The literature supports this notion that bullying problems are often addressed ineffectively (Johnston et al., 2009; Lewis, 2006; Vessey et al., 2009). Furthermore, previous literature has found that managers who provide supportive practice environments, who include staff in decision making, enable flexible scheduling, and demonstrate supportive leadership characteristics have lower bullying levels (Frederick, 2014; Lashchinger & Fida, 2014; Laschinger et al., 2012).

Professional practice. Professional practice environments include the factors that enable nurses to work to their full professional scope. Professional practice involves opportunities to learn and grow. In the bivariate analysis, there was a significant inverse relationship between bullying and professional practice ($p<.0001$). These findings support previous literature that professional practice environments influence bullying (Einarsen et al., 2003; Johnson, 2009; Lewis, 2006; Roche et al., 2010; Zapf & Einarsen, 2005).

The reason for this association between bullying and professional practice may be related to the culture that medical-surgical nurses are exposed to. Medical-surgical units tend to have newer

nurses, with many of these new nurses beginning their careers on these units. They lack knowledge and experience with professional practice opportunities. Newer nurses rely on their senior nurses and management for guidance and support. This makes medical-surgical nurses more susceptible to bullying because of their inability to work to their full scope of practice.

Control/autonomy. In the bivariate analysis, there was a significant inverse relationship between bullying and control/autonomy ($p<.0001$). Previous research supports this study's findings that control/autonomy is significantly related to bullying (Agervold & Mikkelsen, 2004; Baillien et al., 2011; Demir & Rodwell, 2012).

The association between bullying and control/autonomy may be related to an imbalance in power. As mentioned earlier, medical-surgical units tend to have more newer nurses and the lack of nursing experience makes junior nurses more susceptible to bullying behaviors. This notion is supported in the literature, that the imbalance of power leaves the victims of bullying in situations where they feel like they cannot defend themselves (Einarsen et al., 2003; Lutgen-Sandvik et al., 2007; Zapf & Einarsen, 2005).

Conversely, the literature supports that high levels autonomy and empowerment, are associated with lower levels of workplace bullying (Baillien et al., 2011; Einarsen et al., 1994; Hoel and Salin, 2003; Leymann, 1996; Quine, 2001; Rayner et al., 1999; Vartia, 1996; Zapf et al., 1996; Zapf, 1999). These findings may be simply the lack of control and autonomy leaves nurses with fewer perceived choices and more susceptible to bullying. Overall, perceived lack of control is associated with many organizational variables; however, many of these variables are closely related to a manager's influence.

Staffing and Resources. Staffing and resources encompasses staffing ratios/workload and rewards, such as pay/benefits**.** In this study, there was a significant inverse relationship between

bullying and staffing/resources ($p<.0001$). These findings lend support to previous research (Baillien et al., 2011; Einarsen et al., 1994; Hoel & Cooper, 2000; Roche et al. (2010); Salin, 2001; Vessey et al., 2009).

The association between staffing and resources and bullying may be related to experienced staff becoming overworked due to increased stress and workloads with many new nurses on medical-surgical units in need of attention and guidance. Medical surgical units are also known to have high turnover and many new nurses, therefore, senior nurses are constantly in the role of mentoring new staff. This may cause senior nurses to feel overworked, and on the flip side, new nurses may feel ignored.

As well, preceptors report that their workload and responsibilities increase with being a preceptor (Dziedzic, 2010; Kemper, 2007; Yonge, et al., 2002). Thus, a need for appropriate ratios of senior nurses to junior nurses is important so work relationships do not reach the level of bullying or harassment. This may explain the current findings because the study sample of less experienced nurses rely on senior nurses; thus, senior nurses act as one of the most valuable resources to newer nurses. Without proper resources, chances of being bullied increase.

Positive scheduling climate involves the type and amount of hours nurses work. In the bivariate analysis, there was a significant inverse relationship between bullying and positive scheduling ($p=.0064$). This finding supports the literature that reports that bullied employees reportedly have inflexible scheduling (Einarsen et al., 1994a; Hoel & Cooper, 2000; Rodwell & Demir, 2012; Vartia, 1996).

These findings may be related to nurses enjoying better flexibility over their schedules and consequently enjoying their work environment more. Flexible scheduling also gives nurses more control, which was also inversely related to bullying. Furthermore, a good portion of this study

sample was younger nurses who belong to generation Y. This generation has grown with different values and work/life balance is a top priority (Lower, 2007); thus, these findings may simply be related to the need to have more control over their schedules so they can have a better work/life balance.

Nursing competence. Competency is the ability of a nurse to integrate the knowledge, skills, and judgment, required to practice safely and ethically in a designated role (CNA, 2000). There was a significant inverse relationship between bullying and nursing competence ($p<.0001$) in the current study. According to others, low levels of nursing competency and self-efficacy can lead to bullying behaviors (Hutchinson et al., 2006a; Hutchinson et al., 2010; Quine, 2001). These findings may be explained by the sample of nurses, who were simply younger and less experienced on medical-surgical units, which makes them more susceptible to bullying. Moreover, although the sample median was 4 years in their current role, perhaps novice nurses require more extended periods of time to acquire a sense of competence. These findings highlight the importance of management focusing on providing more opportunities for novice nurses to increase their competency, which in turn may reduce bullying in this environment.

Bullying and multivariate modeling. The findings from the multivariate ordinal regression model of bullying lend support for a significant relationship between bullying and the organizational influencing factors and authentic leadership. That is, the more positive the perceived work environment, the lower the odds of reporting higher bullying. Similarly, the higher the perceived authentic leadership, the lower the odds of reporting higher bullying. Interestingly, control/autonomy contributed above all the other organizational factors, although the other organizational factors, as a composite measure, were all significant. The rationale for this finding maybe because each of the components of the organizational factors are linked to control/autonomy. Thus, the multivariate regression analysis highlights the greater influence of control/autonomy over all the other factors.

This was not surprising because control/autonomy kept re-occurring as a theme in many of the organizational factors of this study; For example, professional practice involves control over career opportunities, and bullying involves perceived power imbalances, which can lead to a lack of control. Overall, control/autonomy appears to be a central factor in perceived bullying in medical-surgical nurses.

Summary. In summary, workplace bullying was significantly inversely related to all of the organizational influencing factors. A major theme that developed throughout this study was that managers have a lot of influence over a nurse's work environment. Managers have control over many of the organizational factors and the type of leadership style they have can influence bullying in the workplace. Another theme was that younger nurses tend to be more susceptible to bullying, which is similar to the literature. However, an interesting connection between these two themes can be related to the significance of control/autonomy and perceived power imbalances. As indicated throughout this study, managers are in control of much of the nurses; work environment and nurses, especially newer nurses, are more susceptible to bullying. Thus, not only do nurse report the need for control/autonomy, it is considered the most significant factor in relationship to bullying. This connection between management and staff nurse highlights the importance for managers to identify and address bullying behaviors accordingly. Thus, overall there is a need for more mentorship, better orientation programs that teach nurses how to deal with actual and potential bullying situations and more supportive management.

Authentic Leadership

This section will focus on the study results and the associated literature related to authentic leadership. The research questions addressed whether nurses perceived their managers as authentic or not and the relationships between authentic leadership and bullying and each of the other person and

organizational influencing factors, as well as job satisfaction. These questions were explored with bivariate analyses and with a multivariate ordinal regression analysis as well, which will be discussed later.

In this study, authentic leadership was measured by four subscales: transparency, moral/ethical, balanced processing, and self-awareness and a composite total score, which was calculated by averaging the four subscales. Previous researchers have found that the individual subscales failed to add any meaningful incremental validity beyond the common core higher factor (Walumbwa et al., 2010; Walumbwa et al., 2008); thus, the sumscore was used to operationalize authentic leadership. However, the individual subscales are reported to isolate which components were significant in this sample.

According to Avolio et al (2007), high authentic leadership is operationally defined as mean total scores between 2 and 4 and low authentic leadership as mean scores between 0 and 1 on the ALQ. Thus, the study results indicated that the average participant perceived their manager as authentic (mean=2.34). Based on the individual subscales: transparency and ethical/moral rated the highest, and self-awareness the lowest. Since authentic leadership is a relatively new concept, it was difficult to compare to previous literature; however, several studies were applicable and therefore are discussed in this section.

Authentic Leadership and Person Factors

Bivariate analysis demonstrated a significant positive relationship between authentic leadership and five person factors (i.e., age, gender, years of experience in nursing, years of experience on medical-surgical units, and years of experience in current role).

Although age, and years of experience in nursing, medical-surgical nursing, and current role were all significantly inversely correlated to authentic leadership, the correlation with age was the

strongest ($r=-.7791$; $p<.018$). Years of experience and age are closely related, throughout the literature. A rationale for the findings may be that younger nurses perceive their managers as positive because of the degree of power and influence they have over the work environment. Younger nurses may feel more vulnerable and less powerful in the first couple years of practice and will need someone who is aware of their vulnerability but has the power to help guide them. Based on her research, Wong (2012) concluded that the more authentic the leader is perceived to be, the more formal power nurses experiences in their own roles. Thus, authentic managers that are self –aware are already aware of their strengths and weaknesses, thus, they have time and energy to ensure that other nurses are empowered to carry out their work. Overall, having a manager that is authentic may not be as important to senior nurses because they have already acquired years of knowledge, are less in need of a role model, and may be more aware of who they are. On the other hand, younger nurses may value authentic leaders more because they need role models. Thus, authentic leaders help their followers become more self-aware and transparent of who they are (Avolio et al., 2004; Luthans & Avolio, 2003; May et al., 2003); thus, helping their followers strive for authenticity.

Males on average perceived their managers to be more authentic, compared to females. Furthermore, males perceived their managers to be higher on all the subscales, compared to females, with ethical/moral being rated as the highest. This finding may be related to that males in general are more likely to move into leadership positions, compared to females. The literature has documented that males are more likely to be in senior administrative positions (Goudreau, 2012). Thus, they may have more of an understanding of a manager's leadership role and may be able to relate to their managers more. Although self-awareness was not significant in relation to gender, this maybe because of the cell size for males was quite small, therefore, these results may not be valid. Further research would be needed to verify this finding.

Authentic Leadership and Organizational Factors

This study reported a significant relationship between authentic leadership and eight organizational factors, including: workplace bullying, nurse/MD collaboration, management, professional practice, control/autonomy, staffing and resources, positive scheduling, and competence; authentic leadership was also significantly positively related to the outcome of job satisfaction. Furthermore, in the correlation analysis, management had the highest correlation, followed by professional practice. However, because the authentic leadership is a relatively new concept in leadership and especially to medical-surgical nursing, minimal previous research has been published in this area.

Workplace bullying. The relationship between bullying and authentic leadership was discussed in the previous section.

Nurse/MD collaboration. In the bivariate analysis, there was a significant positive relationship between authentic leadership and nurse/MD collaboration ($p<.0001$). Previous research has demonstrated similar results; Giallonardo et al. (2010) found the relationship between authentic leadership and nurse-nurse interaction to be positively correlated ($p<0.01$). According to Giallonardo et al., when new graduate nurses were paired with preceptors who had high levels of authenticity, graduate nurses felt more engaged and satisfied. These findings may be related to the self-awareness component of authentic leadership, as authentic managers would understand that each individual has different needs and contributes to the team in different ways. Being more self-aware can also help with communication in relationships (Giallonardo et al, 2010).

Management. In the bivariate analysis, there was a significant positive relationship between authentic leadership and management ($p<.0001$). Moreover, in the correlation analysis, management had the highest correlation to authentic leadership ($r=.770$; $p<.0001$). The survey questions that were used to address the management component in this study included: support, recognition, praise,

consults and backs up staff in decision making. Previous research has reported similar findings, that nursing staff value a manager that recognizes and supports their contributions to the workplace (Aiken et al., 2002; McNeese-Smith, 1999; Upenieks, 2002).

The reason for this positive relationship may be related to all the subscales of authentic leadership. However, it seems the relationship between authentic leadership and having a supportive and trusting manager is a central theme in this study's findings, which is reflected in the literature as well. Thus, the transparency component of authentic leadership seems most relevant within this context because authentic managers communicate their true intentions, openly share information, and build trust with their followers. This is an essential component for managers of all nurses but especially for younger nurses, who may need more support and encouragement, while starting their nursing careers.

Professional practice. In the bivariate analysis, there was a significant positive relationship between authentic leadership and professional practice ($p<.0001$). Furthermore, in the correlational analysis, professional practice had the second highest correlation to authentic leadership ($r = .549$; $p <.0001$). The reason for this significant relationship may be related to authentic leaders being aware of the need to provide more professional practice opportunities. Previous research demonstrates that work environments that provide access to information, support, and resources and opportunities to learn and grow, and can create work settings that support professional practice (Laschinger et al., 2003). Thus, medical-surgical nurses may need support to practice to their full potential and authentic managers may be able to provide a supportive environment because they are able to analyze problems from diverse view points and consider how those views may fairly shape the challenges their staff are facing (Avolio et., 2007). High correlation between professional practice and authentic leadership may be related to the need of nurses to work to their full scope of practice and authentic managers provide the support necessary to achieve this goal.

Autonomy/Control. Autonomy/control are terms that are often associated with professional practice. Autonomy refers to the degree to which nurses have the freedom to act on what they know (Aiken et al., 1997). In the bivariate analysis, there was a significant positive relationship between authentic leadership and autonomy/control ($p<.0001$). These findings may be related to authentic managers being able to empower nurses to feel like they have more control to act upon their nursing skills. Previous literature supports that the lack of autonomy and lack of power nurses feel can be helped through authentic leadership techniques, such as creating a supportive environment can help nurses feel more self-confident and less defensive and uncertain in decision making (Shapira-Lishchinsky, 2014).

Staffing and resources. In this study, staffing and resources encompasses staffing ratios/workload and rewards, such as pay/benefits**.** In the bivariate analysis, there was a positive significant relationship between authentic leadership and staffing and resources ($p<.0001$).

Previous studies support the argument that authentic managers promote healthy work environments with appropriate staffing through a component of authentic leadership: self-awareness. Self-awareness is the understanding of one's own strengths and weaknesses and understanding how they affect others (Avolio et al., 2007). For example, although less experienced nurses may not be able to handle the same workload as senior nurses, this may be overlooked when assigning patients. While there may be situations of short staffing that are out of the manager's control, the recognition, acknowledgement, and consideration of this situation maybe just as important.

Positive scheduling climate. In the bivariate analysis, there was a positive association between authentic leadership and positive scheduling ($r=0.208$; $p<.0001$). Although management in unionized environments must follow contracts, work schedules are still mainly implemented by management. While there is rarely independence because there are so many rules, there is room for

some flexibility (Ellenbecker et al., 2007; Klemm & Schreiber, 1992) and flexible scheduling is closely related to empowerment.

The reason or this positive association may be related to the balanced processing component of authentic leadership. Authentic managers would understand that different schedules would be required depending on the individual's needs and also that these needs will change over time. For example, during child rearing years, less hours of work maybe more suitable for the nurse; conversely the novice nurse may have student loans, or an interest travelling or pursuing further education, and so may want to work more.

Competence. In the bivariate analysis, there was a positive significant relationship between authentic leadership and competence ($r= 0.367$; $p<.0001$). This positive association may be related to how authentic managers support and empower their staff to practice with high standards. Previous literature supports that authentic managers are self-aware; they are deeply aware how they behave and how they are perceived by others, thus, acting as role models for newer nurses (Avolio et al., 2004). Managers need to ensure their nurses have the necessary resources and support to achieve competence.

Summary

In summary, mean authentic leadership scores and the subscales were all significantly related to all of the organizational influencing factors and the person factors of age, years of nursing experience, years on medical-surgical units, years in current role, and gender. The findings from this study are consistent with the limited other studies that have been published to date. These findings highlight the importance of nurses having a manager whom they can trust, who supports and respects them; in other words, who exhibits many of the characteristics of authentic leadership. Furthermore, these findings contribute to the dearth of existing literature on authentic leadership, by adding

knowledge specific to medical-surgical and lending support for the relationship between authentic leadership and bullying.

Job Satisfaction

This section will focus on the study results within the context of the associated literature related to the outcome of this study, job satisfaction. The research questions addressed the relationship between job satisfaction, bullying and authentic leadership and each of the other person and organizational influencing factors. These questions were explored with bivariate analyses, as well as a multivariate regression analysis.

The study results indicated that the majority of medical-surgical nurses were satisfied (n=150; 53%), 12% were very satisfied (n=35), 14% were neutral (n=40), 18% were somewhat dissatisfied (n=54), and 3% were not at all satisfied. These findings are contrary to most of the literature. For example, several researchers have found that nurses on medical-surgical units are not satisfied (Gowell & Boverie, 1992; Ingersoll et al., 2002; Kalisch et al., 2010; Shields & Wards, 2001; Wakefield et al., 1988). On the contrary, Boyle et al. (2006) found that medical-surgical nurses ranked more moderately regarding job satisfaction in their study, and ED nurses were the least satisfied. Boyle et al. (2006) concluded that their disparate findings may have been related to their use of a broader range of comparison unit types and they measured more specific domains of job satisfaction. Boyle et al. (2006) noted that medical-surgical nurses were among the youngest in age and lowest in average years in practice. A possible rationale for these different findings may be related to sampling bias in that the nurses who participated in this study may have been proactive and perhaps motivated to take steps to improve their environment. As well, arguably, dissatisfied nurses would be less likely to participate in research.

Job Satisfaction and Person Factors

The only person factor that was significantly related to job satisfaction was gender; however, area of employment was approaching significance (p =.06). In this study, nurses on medical units were more likely to be dissatisfied (dissatisfied/very dissatisfied), than surgical nurses and the 'other' category. While the insignificant findings related to age were somewhat surprising, on examination of these findings, it is of interest to note that the most dissatisfied nurse were markedly younger that any of the other job satisfaction categories. However, it is important to note that small cell sizes likely accounted for these results not reaching significance. Although the research evidence related to age and job satisfaction are somewhat mixed. For example, much of the literature reports that older nurses have a greater level of job satisfaction (Gurkova et al., 2012; Ingersoll et al., 2002; Price & Mueller, 1981; Shields & Wards, 2001; Taunton et al., 1997); other studies have reported that younger nurses have greater job satisfaction (Giallonardo et al., 2010; Kovner et al., 2009; Laschinger, 2012; Shields, & Wilkins, 2009). Furthermore, Takase et al. (2009) concluded that insignificant findings related to job satisfaction and age may be related to different generations having different work related values and needs, and these differences need to be taken into account.

Gender. In the bivariate analysis, there was a significant association between gender and job satisfaction (p=.028); that is, female nurses reported higher job satisfaction than males. This studys' finding is consistent with previous literature, that female nurses are more satisfied than male nurses (Clark, 1996; Kalisch et al., 2010; Kovner et al., 2009; Shields & Ward, 2001). One reason cited in the literature for this positive association is that men are the minority in nursing and feel less included (Kalist, et al., 2011). However, in this study, there were very few male participants; therefore further research is needed to verify these findings.

Area of employment. In the bivariate analysis, there was a positive association between area of employment and job satisfaction (p=.055), which was approaching significance. That is, studys' participants working on medical units were reportedly the most dissatisfied (very

dissatisfied/dissatisfied). The literature is mixed as to which units are the least satisfied; however, most research combines medical-surgical unit nurses. Medical unit nurses may be less satisfied because they have higher nurse to patient ratios and patients with more chronic and complex needs. Although, the 'other' category of employment also showed higher dissatisfaction than the surgical units, this finding is difficult to interpret because we do not specifically know where the nurses worked and this cell size was small.

Job Satisfaction and Organizational Factors

The OFPNR framework will be used to guide the discussion in this section on the organizational factors that were significantly related to job satisfaction. All the organizational factors, except positive scheduling climate were significant.

Workplace bullying. The bivariate analysis revealed a significant inverse relationship between job satisfaction and workplace bullying. This finding is consistent with previous literature that demonstrates that job satisfaction is inversely related to bullying (Bjorkqvist, 2001; Duddle & Boughton, 2007; Einarsen, 2000; Hegney et al., 2006; Hutchinson et al., 2006a; Murray, 2009; Quine, 2001).

The rationale of the association between job satisfaction and workplace bullying may simply be related to the negative consequences of bullying influencing a nurse's job satisfaction. Such consequences may include: stress, irritability, anxiety, sleep disturbance, excessive worry, impaired social skills, depression, fatigue, loss of concentration, and emotional pain (Cleary et al., 2010; Murray, 2008; Yildirim, 2009); thus, these consequences may reflect how nurses rate their level of job satisfaction.

Authentic Leadership. Bivariate analysis revealed a positive significant relationship between job satisfaction and authentic leadership. More specifically, the findings from this study

indicated that all four subscales and the mean composite score for authentic leadership were significantly related to job satisfaction. In other words, more satisfied participants were more likely to perceive their managers as authentic. Moreover, in participants who were reportedly very satisfied, transparency scores were higher than the other sub-scales and the composite score. These findings were similar to previous research that reports managers who offer support, praise, recognition, and promote respectful relationships have higher job satisfaction and better work environments (Avolio et al., 2004; Giallonardo et al., 2010; Laschinger et al., 2012; Walumbwa et al., 2008; Wong et al., 2010).

These findings may be related to authentic managers having the knowledge and skills to provide healthy working environments. As noted in the literature, job satisfaction is achieved through various organizational variables, thus, a manager ultimately has control over many of them. Components of authentic leadership that help managers increase nurse staff job satisfaction may be related to a manager's transparency. Thus, managers who are trustful, fair, supportive, and who praise, and recognize staff are valued traits perceived by nursing staff (Duffield et al., 2010; Ellenbecker et al., 2007; Tang, 2003). Furthermore, the ethical/moral component of authentic leadership involves leading by strong internal morals; for example, a manager who shows respect towards staff has been found to be a major reason staff decided to stay in an organization (Ulrich et al., 2005). Another component of authentic leadership is balanced processing, which involves dealing seen all perspectives of a conflict before making a decision. Balanced processing is useful when dealing with conflict, such as, bullying, which is associated with job satisfaction. Lastly, self-awareness is another component of authentic leadership, which is helpful in a manager's ability to be able to identify and be aware of their own strengths and weaknesses. Thus, by acknowledging what they know and don't know, they can develop strategies to improve themselves and ultimately their work environment.

Nurse/MD collaboration. Collaboration involves communication among healthcare professionals, which is essential for job satisfaction. In the bivariate analysis, there was a positive significant relationship between job satisfaction and nurse/MD collaboration ($p<.0001$).

Findings from this study are similar to previous research, in that positive work relationships are associated with a higher level of job satisfaction (Adams & Bond, 2000; Aiken et al., 2001; Nelson et al., 2008; Price & Mueller, 1981; Shields, & Wilkins, 2009; Rafferty et al., 2001; Rosenstein, 2002; Simons, 2008). According to Adams and Bond, cohesive working relationships are one of the most important factors affecting job satisfaction and are threatened during recruitment and retention difficulties, which are common to medical-surgical areas. Therefore, more programs are needed to teach staff strategies to help support and communicate with each other more effectively.

Management. In the bivariate analysis, there was a positive significant relationship between job satisfaction and management ($p<.0001$). This finding is consistently supported by previous research that nurse managers are among the most significant influencing factors on staff job satisfaction in the nursing work environment (Cohen et al., 2009; Duffield et al., 2010; Kovner et al., 2006; McGurie & Kennerly, 2006; Sawatzky & Enns, 2012).

A primary rationale for the manager's significant influence on job satisfaction in medical-surgical nurses may be related to the amount of control and influence a manager has over many of the organizational factors. More, specifically the type of leadership a manager has may be the main reason for the positive relationship between job satisfaction and management. Shapira-Lishchinsky (2014) concluded that authentic leadership techniques, such as promoting a supportive environment can help nurses feel more self-confident and more satisfied (Shapira-Lishchinsky, 2014).

Professional practice. In the bivariate analysis, there was a significant positive relationship between job satisfaction and professional practice ($p<.0001$). Previous research has supported the findings in this study that nurses who rated highly on professional practice factors are more satisfied (Aiken et al., 2001, 2002, 2008; Hall & Doran, 2004; Havens & Aiken, 1999; Mark et al., 2003).

The reason for this significant association between job satisfaction and professional practice may simply be related to the amount control a nurse feels they have over the work environment, which in turn, may also be related to support from management to provide these opportunities for practice. Not only does professional practice affect job satisfaction, but it also has a strong impact on lowering nursing turnover (Mark et al., 2003). Mark et al. concluded that professional nursing practice was enhanced by the availability of support services. The availability of these services would in part be under management's control.

Autonomy/Control. In the bivariate analysis, there was a positive significant relationship between job satisfaction and autonomy/control ($p<.0001$). Previous studies support the hypothesis, that job satisfaction is related to autonomy and control (Atefi et al., 2014; Atefi et al., 2013; Zangaro & Soeken, 2007). Control/autonomy has being a re-occurring theme throughout this discussion, not only in job satisfaction but also in bullying and authentic leadership as well. A rationale for this finding may be related to the fact that control/autonomy is closely interconnected with all of the organizational factors. Therefore, it is manager's role to help nurses to feel empowered and encouraging staff to make decisions in their work (Laschinger, 2012; McCloskey, 1990), which, in turn, will likely lead to job satisfaction.

Staffing and resources. In the bivariate analysis, there was a positive significant relationship between job satisfaction and staffing and resources ($p<.0001$). This finding is consistent with previous research, in that nurses who work in areas with inadequate staffing and limited resources are

less satisfied (Aiken et al., 2002; Chen et al., 2008; Davidson et al., 1997; Kovner et al., 2009; Shields, & Wilkins, 2009).

A reason why job satisfaction is positively associated with staffing and resources may be related to the amount of control that nurses feel over their environment. Staffing and resources are generally out of the nurses' control; thus, this perceived lack of control can cause job dissatisfaction. Therefore, managers must address concerns related to staffing and resources. Providing staff with some control over staffing and resources, such as flexible scheduling would likely have a favorable impact on job satisfaction.

Competence. In the bivariate analysis, there was a positive significant relationship between job satisfaction and competence ($p<.0001$). Results from this study were similar to previous research that reported that a lack of competence can influence job satisfaction and turnover (Choi, 2010; Kramer, 1974; Oermann et al., 2010; Tyler et al., 2012). The reason for this association may be related to the factors that influence a nurse's competence, which includes: professional experience, education/professional development, and a higher level of independence. Previous research has indicated that nurses on medical-surgical units are relatively younger with less experience. Kramer (1974) concluded that problems with nursing competence are associated with students being unaware they were learning the ideal rather than the norm. As many new graduates are first employed on medical-surgical units, it is particularly important for orientation program to include not only mandatory policies, rules, and expectations of nursing duties but also for new nurses to understand the stages of competence, common workplace behaviors to be aware of (e.g., bullying) and how to deal with them. As well, nursing education programs should be preparing nursing students for the realities of clinical practice, to include teaching them that competence takes time.

Job satisfaction and multivariate modeling. In the multivariate ordinal regression analysis, control/autonomy and area of employment were significant predictors of job satisfaction. Moreover, bullying was approaching statistical significance (p=.06). Although, authentic leadership and the other organizational factors were significant in the bivariate analysis, they were not significant in this multivariate analysis. This finding may be explained by the fact that components of authentic leadership and the organizational factors are already measured in control/autonomy. Understanding how control/autonomy can override all of the other organizational factors can be understood more clearly by examining the questions related to control and autonomy, which included: control over what goes on at work, opportunities for career development, amount of responsibilities, control over work, participation in organizational decision making, and autonomy over decision making. Furthermore, this regression model amplifies the significance of autonomy/control and reinforces its central importance in this study, as it appears to be a re-occurring theme throughout the data. The rationale for nurses who work on medical units being less satisfied than surgical unit nurses requires further study.

Summary. In summary, job satisfaction was positively related to all of the organizational variables, except positive scheduling climate, in the bivariate analyses. The multivariate analysis highlights the significance of control/autonomy in job satisfaction; as well, working on a medical unit predicted decreased job satisfaction in this study.

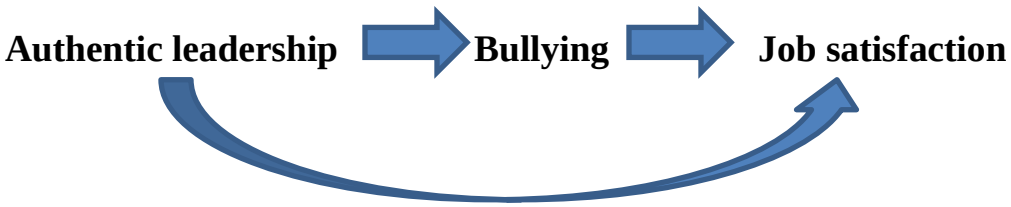
Conceptual Framework

The Organizational Framework for Predicting Nurse Retention (OFPNR; Sawatzky & Enns, 2012) was used to guide the research and to address the study questions. Therefore, the following section will discuss how well this framework achieved this goal.

The purpose of this thesis study was to specifically focus on exploring if there is a relationship between bullying, leadership style, and the outcome of job satisfaction among medical-surgical nurses. The adaptation of this framework involved adding bullying and authentic leadership as influencing factors and focusing on job satisfaction as the study outcome. As predicted, based on the bivariate and multivariate regression analysis, there were significant associations between bullying, authentic leadership, and job satisfaction, thus, lending support for the adapted OFPNR being an appropriate framework to address the study purpose. However, further research, using data analysis strategies such as path analysis is necessary to substantiate or refute these findings within the context of the OFPNR.

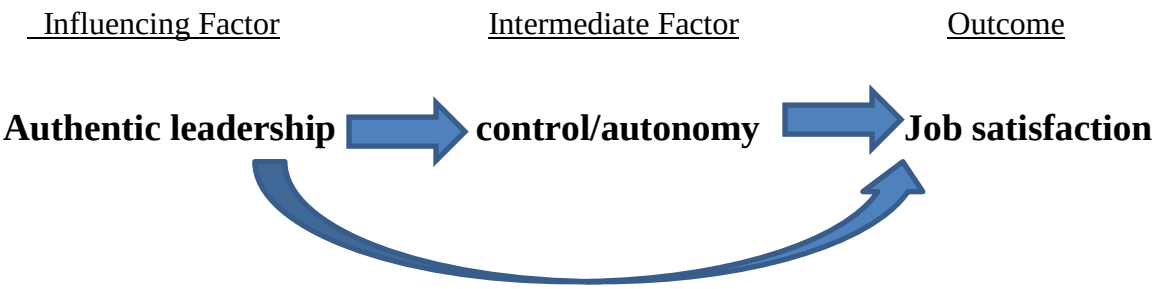
It is important to note that during the study planning process there was considerable discussion as to where bullying should be placed within the framework; however, the primary rationale for the placement of this concept within influencing factors was that bullying is a good fit as an organizational factor, which influences job satisfaction. As well, authentic leadership was also a good fit as an organizational factor, because it is closely linked to management. Thus, the OFPNR was adapted to accommodate these concepts. However, after analyzing the data, there were several additional possibilities regarding the placement of bullying and control/autonomy within this framework. Firstly, bullying may be viewed as an intermediary variable between authentic leadership and the outcomes of job satisfaction (see Figure 4). In other words, increased authentic leadership leads to decreased bullying and in turn leads to increased job satisfaction. The rationale for this placement is based on the results from this study that there were significant relationships between these three variables; however, the direction of the relationships cannot be verified based in the current analyses.

Figure 5. OFPNR with Bullying as an Intermediary Factor.



Similarly, the overall significance of control/autonomy, authentic leadership, and job satisfaction in particular, also raises a similar question. For example, in Figure 5, control/autonomy is hypothesized to be an intermediary factor between authentic leadership and job satisfaction.

Figure 6. OFPNR with Control/Autonomy as an Intermediary Factor.



In summary, the OFPNR was a good fit for the purposes of this study. However, the findings raised several important questions related to the placement of bullying and control/autonomy, within this framework. Therefore, further research is needed to investigate these relationships more within the context of the OFPNR.

Study Limitations

This section involves a critical analysis of limitations of the study design, methods, and results. This analysis will determine the applicability and generalizability of the results.

This study utilized a cross-sectional survey design. Cross-sectional studies are used to explore one or more variables at a given time. They are useful to determine associations rather than causality and prevalence, rather than incidence. One of the disadvantages is that cross-sectional surveys do not permit distinction between cause and effect (Mann, 2003). Nonetheless, data from this study provides insights for future studies, such as prospective cohort studies or randomized control trials, which are more rigorous. However, this study achieved a relatively large sample (N=317), which adds to the validity of this data.

This study also used convenience sampling, which is sometimes not representative of the target population because participants easily self-select to be part of the study (Statistics Canada, 2013). Another limitation, was that only three hundred and seventeen (N=317) nurses participated in this study, out of 2061 medical-surgical RNs in Manitoba (personal communication: Kristen Mitchell, Communications Coordinator, CRNM, 27/01/14), a response rate of 15%, which is low. However, based on the demographic results, the sample appeared to be relatively representative of the target population.

Another limitation relates to instrumentation. In this study, authentic leadership was measured by the ALQ. Although it is the most widely used instrument for measuring authentic leadership, this is a relatively new concept and this is also a relatively new instrument. While the study results lend support to the concept, further research is needed to ensure that it captures the essence of what authentic leadership is.

In summary, although there were several study limitations, the participants overall appear to be relatively representative of the current population of Manitoba medical-surgical nurses. Although a cross-sectional survey design was used, which does have its disadvantages, the relatively large

sample contributes to the study rigor. Finally, a relatively new instrument was used to operationalize the concept of authentic leadership; however, the results lent support to the concept.

Implications for Nursing

Previous literature has demonstrated the significant problem of bullying in nursing and how it influences job satisfaction. However, the quest to find solutions and strategies to address bullying, is still a cause of concern all over the world and in multiple of disciplines. This study has enhanced nursing knowledge and has contributed by examining the relationship between bullying, job satisfaction, and nurses' perceptions of their manager's leadership style. This study also addresses the gaps in the literature relating specifically to bullying and authentic leadership in medical-surgical nurses. While these results will be most helpful for nurse managers and nursing staff, these findings can contribute to other areas of nursing, as well. This section will focus on implications for nursing administration, practice, education, and future research.

Administration. Although there are multiple influencing factors that impact a nurse's work environment, a common theme that kept reoccurring in this study was the influential role of nurse managers. Thus, when managers recognize and understand the relationship between job satisfaction and workplace bullying, it can help prevent bullying or identify and address bullying behaviors in the early stages. Furthermore, the findings also suggest that managers who have authentic leadership skills will likely not be bullies themselves and may be better equipped to deal with bullying behaviors in others, which in turn will impact on job satisfaction. Similarly, the important role of the manager in influencing many of the organizational factors, to reduce bullying and enhance job satisfaction was a common theme throughout this study.

In this study, the most bullied participants rated their managers lowest in authentic leadership self-awareness. Therefore, implications for administration should focus on strategies that enhance

authentic leadership skills, and specifically self-awareness. Part of self-awareness is to be aware of what you know and what you don't know. Furthermore, it is about identifying your strengths and weakness. Managers should develop strategies that enable them to communicate openly and honestly, while exposing their vulnerabilities; therefore, a safe place to address concerns is necessary. Thus, a strategy for all managers but especially newer managers may be to have regular meetings with a more senior manager who can mentor them in the development of greater self-awareness. Revealing lack of knowledge is important, so that senior managers can help guide novice managers to better solutions. In addition, the most bullied participants rated balanced processing as the second lowest authentic leadership component in their mangers. This is a concerning because balanced processing is the component of authentic leadership that helps managers deal with conflict. Therefore, strategies to enhance balanced processing may revolve around mentorship programs to observe how other managers deal with conflict. Moreover, simply enhancing knowledge through workshops on preventing bullying and addressing bullying behaviors may help as well.

Implications for administration include addressing the organizational factors that impact bullying and job satisfaction, many of which are related to increasing staff control/autonomy. For example, managers can significantly influence nurse/MD collaboration. Therefore, management strategies should be focused on ensuring that nursing staff have the opportunity learn and practice communication skills and assertiveness in decision making, such as during daily rounds with physicians. Similarly, implications for administration regarding professional practice can be closely related to control and autonomy. Professional practice includes: opportunities for career development, education, advancements, opportunities to serve on nursing committees, and to be involved in policy decisions. Therefore, strategies that can enhance professional practice revolve around managers providing the opportunities, support and encouragement to pursue activities for career advancements.

Although lack of resources is a challenge for most managers, it is important for managers to strive for better resources. Strategies that should be considered, involves communication with staff and supervisors to get accurate information regarding patient-nurse ratios, workloads, staff mix, and equipment. Another strategy would involve communication with higher administration and directors regarding budgetary needs and negotiations for better resources. Similarly, managers often have minimal control over scheduling, due to union rules and regulations; however, involving nursing staff in the scheduling process may be an effective strategy to reduce bullying and enhance job satisfaction.

Thus, clearly managers need to have the appropriate skills to empower nurses to build their self-confidence, to create an environment where nurses perceive they have autonomy and control over their work life. Therefore, developing authentic leadership skills appears to be an ideal strategy for managers to positively influence their work environment and increase job satisfaction in the workplace.

Education and Practice

Implications for education include a focus on competence, as competence is related to job satisfaction and bullying. Education should begin with educating nurse managers. If control/autonomy is the connection between nurse managers and the nursing work environment, then the education of how to enhance a nurse's competence cannot be underestimated. Orientation programs for new nurse managers should focus on educating them to fully understand the importance of their role as a manager. Novice managers must learn how to encourage, support, and provide opportunities for nurses to feel more in control over their work and to achieve competence, so they can practice to their full scope of practice. Furthermore, bedside nurses must also have access to educational opportunities through orientation programs and ongoing workshops so that they can

integrate knowledge into practice, such as, enhancing communication skills, and gaining confidence and assertiveness in their decision making; thus, nurses will feel more in control and perceive less power imbalances with their work relationships.

Implications for education regarding bullying, should involve educational strategies to prevent bullying and to identify and manage bullying behaviors. This education should be initiated prior to entering the workplace, in undergraduate nursing schools. The impact of bullying should not be underestimated within the workplace, with extensive measures, such as, mentorship programs, and workshops being offered to all nursing staff regarding bullying and conflict resolution. Although educating staff is important, managers are the ones who hold the key to the well-being of the nurse's work environment; therefore, education should also focus on teaching managers how to optimize the nurses work environment, through strategies to increase job satisfaction and minimize bullying.

Future Research

Although this study has made a significant contribution to the existing literature in regards to bullying and authentic leadership, these concepts are still relatively new and have not been widely studied in medical-surgical nursing; thus, future research should continue to focus on bullying and authentic leadership, in particular in the nursing population.

Medical-surgical units tend to employ many newer nurses, who are most often the targets of bullying. For that reason, future research should explore the gap between academia and clinical practice. Research questions should address whether new nurses are fully prepared for the clinical setting and what resources are needed for novice nurses to reduce bullying and achieve job satisfaction. Furthermore, the role of academia in providing education in undergraduate nursing programs should be explored.

Managers are known to be one of the biggest perpetrators of bullying. Research has reported that many managers do not know how to deal with bullying behaviors. For this reason, future research should use a mixed method approach and explore, from a manager's perspective, why this is happening and methods to deal with it. Research questions should address the readiness for nurses taking on a managerial role, managers who are perceived as authentic have higher job satisfaction and less bullying among their staff nurses. Therefore, future research should focus on how managers learn to be authentic leaders. Future research should also focus on developing authentic leadership skills and exploring the organizational outcomes of authentic leaders.

Future research should use the OFPNR to explore different alternatives, including bullying and control/autonomy as an intermediary factors. Furthermore, future studies should explore the direction of these relationships through prospective cohort studies, and using strategies such as path analysis. Finally, control/autonomy was a significant factor in relation to bullying, authentic leadership, and job satisfaction; interestingly, this variable was more significant than any of the other organizational factors. Therefore, future research should explore the concept of control/autonomy and how it impacts the nursing work environment.

Summary

The discussion chapter examined the main concepts of this study: bullying, authentic leadership, and the outcome of job satisfaction within the context of the related literature. Bivariate analysis found many significant relationships among bullying, job satisfaction, and authentic leadership. Moreover, multivariate regression analysis revealed a significant relationship between bullying and job satisfaction. Interestingly, control/autonomy was more significant than any of the other organizational influencing factors. Furthermore, the OFPNR was an appropriate fit for this study, although future studies could consider possible adaptions to this framework. While this study

had several limitations, the findings appear valid, and build on previous scientific evidence. Lastly, implications for nursing administration, education, practice, and future research were discussed.

Conclusion

The overall purpose of this study was to explore the relationship between bullying, authentic leadership, and job satisfaction in medical-surgical nurses. This was accomplished by using the OFPNR as a framework to guide the study. In addition to exploring these three main study concepts, this framework also allowed for the examination of relationships between influencing factors (i.e., organizational climate, and person factors). Bivariate and multivariate regression analysis revealed many significant relationships among the main concepts and among the influencing factors. Thus, the OFPNR was a good fit for this study.

This study utilized a quantitative approach, using a cross-sectional online survey with a relatively large sample (N=317), which added to the validity of this research. The three main study concepts were operationalized with reliable and valid instruments: the PNWE, NAQ-R, the ALQ, and a demographic questionnaire.

This study verifies previous literature relating to bullying, authentic leadership and job satisfaction. Furthermore, this study highlighted the importance of the nurse manager's roles in promoting healthy work environments. Previous literature has demonstrated the importance of control/autonomy on the work environment and nurse job satisfaction; however, this study amplified the significance, as this factor was more significant than all of the other organizational influencing factors in the multivariate job satisfaction regression analysis. This is a key finding that also links to authentic leadership, because managers who are authentic leaders can influence organization factors to increase control/autonomy in their staff. Thus, this study contributes to a relatively small body of

existing evidence related to the relationship between authentic leadership, bullying and job satisfaction.

Lastly, this study contributes to the voice of victims of bullying. Historically, workplace bullying has been poorly addressed; poorly for the victims and poorly for the organizations. Strategies and solutions to eliminate bullying in nursing are still a cause for concern and the source of frustration for victims of such abuse; however, this study is a reminder that bullying is a problem that can not be ignored and a reason for cautious optimism that bullying can be eliminated in the future.

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LIST OF APPENDICES

APPENDIX A1

INVIITATION EMAIL TO PARTICPATE

ATTENTION: MEDICAL-SURGICAL NURSES

Do you work in a medical-surgical area in a hospital in Manitoba? Are you a staff nurse, clinical resource nurse (CRN), or an educator? If so, keep reading, because you can make a difference!

You are invited to participate in a research project designed to explore and describe factors that may influence nurses' intent to leave the medical-surgical area. This e-mail is being sent by the CRNM on behalf of a researcher ([redacted]) and a graduate student ([redacted] in the Master of Nursing program from the Faculty of Nursing at the University of Manitoba. Our goal is that the knowledge and insights gained from this research will lead to the development of strategies for nurse retention.

Participation in the study is voluntary. If you are interested, and agree to participate, it will involve completing the enclosed questionnaire package. This should take approximately 20 minutes of your time. **Participants are invited to enter their names to win one of 4 Chapters gift certificates for $100 each**. The two 'early bird' draws will be held on (1 week post-e-mail) and the final 2 names will be drawn at the end of the study.

Thank-you for taking the time to read this information. You can make a difference! It is through research projects such as this one that we will gain a better understanding of the retention issues and strategies to retain nurses in the medical-surgical areas. Please click on the following link for more study information, the consent form and the online survey [Insert Survey Link]

Sincerely,
[redacted]*
Faculty of Nursing, University of Manitoba
Principal Investigator: The Medical-Surgical Nurses Retention Study
[redacted]

[redacted]
Graduate student
Faculty of Nursing, University of Manitoba
PH#: [redacted]

*contact for further information

*Note: this study is approved by the Education and Nursing Research Ethics Board and concerns and complaints can be directed to the Human Ethics Coordinator, [redacted]

APPENDIX A2

SECOND INVITATION TO PARTICPATE

2nd Email [First reminder – sent 10 days after 1st email]:

This email is being sent to you on behalf of researchers from the Faculty of Nursing, University of Manitoba.

Approximately ten days ago you were sent an email via the CRNM, on behalf of the researchers, to request your participation in a confidential online survey of all Medical-Surgical Nurses in Manitoba. The survey will gather information from you about the factors that affect the retention of nurses in the Medical/Surgical area of practice. You are asked to complete an online confidential questionnaire, which should take only about 20 minutes to complete. Your response to this survey is important to gather information which can be used the development of strategies that help to retain nurses in Medical/Surgical units. If you complete the survey, you will have the opportunity to enter into a draw to win 1 of 2 - **$100 gift cards to Chapters Bookstore.**

We look forward to receiving your valuable input. If you are interested in completing the survey and/or would like more information, please go to the following link: [Insert Survey Link]

Sincerely,
[redacted]
Faculty of Nursing, University of Manitoba
Principal Investigator: The Medical-Surgical Nurses Retention Study
[redacted]

[redacted]
Graduate student
Faculty of Nursing, University of Manitoba
[redacted]

*contact for further information

*Note: this study is approved by the Education and Nursing Research Ethics Board and concerns and complaints can be directed to the Human Ethics Coordinator, [redacted]

APPENDIX A3

THIRD AND FINAL INVITATION TO PARTICPATE

3rd Email [Second and final reminder - will be sent 21 days after 1st email]:

This email is being sent to you on behalf of researchers from the Faculty of Nursing, University of Manitoba.

This a final reminder to consider participating in an online survey to gather information which will help us develop strategies to retain nurses in the Medical/Surgical area of practice. If you complete the survey, you will be asked if you would like to be entered into a random draw of participants to win one of two $**100 gift certificates to Chapters BookStore**.

We realize you have a busy schedule but hope you will be able to find the time to complete this 20 minute survey as soon as possible as we would like to complete data collection by [insert date].

For more information and to complete the survey please click on the following link: [Insert Survey Link].

Thank you for considering this request.

Sincerely,
[redacted]*
Faculty of Nursing, University of Manitoba
Principal Investigator: The Medical-Surgical Nurses Retention Study
[redacted]

[redacted]
Graduate student
Faculty of Nursing, University of Manitoba
[redacted]

*contact for more information

*Note: this study is approved by the Education and Nursing Research Ethics Board and concerns and complaints can be directed to the Human Ethics Coordinator, [redacted].

APPENDIX B

SURVEY CONSENT

UNIVERSITY OF MANITOBA | Faculty of Nursing

Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone: (204) 474-7452
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RESEARCH SUBJECT INFORMATION & CONSENT FORM

Project Title: The Medical-Surgical Nurses Retention Study

Researcher(s): [redacted]
Principal Investigator:
Faculty of Nursing, University of Manitoba
[redacted]

[redacted]
Graduate student
Faculty of Nursing, University of Manitoba
[redacted]

Sponsor: Kathleen and Winnifred Ruane Graduate Student Research Grant

This consent form, a copy of which you can print for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Study Purpose

The main purpose of the Medical-Surgical Nurses Retention Study is to explore and describe factors that may influence nurses' intent to leave medical-surgical areas. The survey contains seven sections, which address questions about your current work environment, including positive and negative experiences in the workplace, and your manager's leadership style, as

well as your current job satisfaction, intent to leave, and demographic questions such as your education, employment status and income.

The study is being conducted by a nurse researcher and a graduate student from the Faculty of Nursing, University of Manitoba. Ms. Bennett's thesis topic is specifically related to bullying and leadership styles. Our goal is that the knowledge and insights gained from this research will lead to the development of strategies for the retention of medical-surgical nurses.

Participants

We are asking all staff nurses, clinical resource nurses (CRNs) and educators, who are currently employed in medical-surgical areas in Manitoba to participate in this study. Your participation will involve completing a confidential online survey located in a password protected account at Fluidsurveys.com. The survey is expected to take about 20 minutes to complete. Please consider participating in this study

Risks/Benefits

There are no anticipated risks to you for participating in this research. If at any time during the completion of the questionnaire, you become upset, please discontinue completing the survey immediately and contact your employee resources department to seek assistance. If you exit the survey prior to submission, your responses will not be part of the survey/study. However, it will not be possible to delete the responses you have provided as your responses are recorded anonymously. You may not benefit directly from participation in this research; however, the study results will contribute to a better understanding of the issues related to nursing retention in medical-surgical areas. There will be no financial costs for you to participate; the only cost is your time to complete the survey. You will not be paid for your participation in this study. Although you will not be paid for your participation, study participants are invited to enter their names to win one of 4 Chapters gift certificates for $100 each. The first 2 'early bird' draws will be held on (1 week post-e-mail) and the final 2 names will be drawn at the end of the study.

Confidentiality

All information you provide to the Medical-Surgical Nurses Retention Study will be kept strictly confidential. The link you follow to complete the survey is a general link common to all survey participants. As such, completion of this survey is anonymous unless you indicate your desire to receive a summary report of the study results and provide your email address to which you would like report sent. In this case, only employees of the Manitoba Centre for Nursing and Health Research (MCNHR) located in the Faculty of Nursing, University of Manitoba, will know you have participated. The MCNHR will be managing the data collection. Only MCNHR employees will have access to the password protected survey account on Fluidsurveys.com. Once data collection is complete, the MCNHR will review the data collected to ensure no personal identifiers were recorded. All such identifiers will be removed from the data before

the data is given to the researchers in the form of an electronic file. No copies of the data will be kept by the MCNHR. The MCNHR will only keep a record of the email address of participants who have indicated they would like to receive a summary report. Only the identified researchers will have access to the study data after data collection is complete. All data will be kept on the password protected computer of the principal investigator of this project (Dr. Sawatzky). Any hardcopies of data analysis output will be kept in a locked filing cabinet in the office of the principal investigator. Any hardcopies of data analysis output will be kept in a locked filing cabinet in the office of the principal investigator (Rm 281 HGC for Nursing; UofM). All electronic data will be kept for 10 years and then deleted. Hardcopies of study data will be disposed of in confidential waste after the same time period.

Dissemination

The results of this study may be published in a peer-reviewed journal and presented at a conference. If you would like to receive a summary of the study results, please indicate your willingness to receive this report by answering the applicable question provided at the end of the survey. The MCNHR will send you a copy of the summary report by email when it becomes available in November, 2014. After the summary report is sent to you the MCNHR will delete your email address from their records.

Consent

Completion of this survey indicates that you have understood to your satisfaction the information regarding participation in the research project and consent to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. You may choose to discontinue your participation in this survey at any time by exiting the survey and your responses will not be part of this study. However, once you have submitted the survey it will not be possible to remove or change your responses because they are recorded anonymously. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.
The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Education and Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) [redacted]. Print a copy of this consent form to you to keep for your records and reference.

If you agree to participate in the survey, we ask that you please click on the next button at the bottom of the page to be taken to the first survey questions.

Do not complete the Fluid Survey Questionnaire unless you have a chance to ask questions and have received satisfactory answers to all of your questions.

For further information, please contact:

[redacted]

APPENDIX C

THE MEDICAL-SURGICAL NURSE RETENTION SURVEY:

The Perceived Work Environment Scale

This part of the questionnaire includes statements about perceptions of the nursing work environment. For each statement, please indicate whether you agree/disagree that this statement is true in <u>your current work environment</u>. Please circle the most appropriate response, using the following scale:

	Strongly Disagree. 1	Disagree Somewhat 2	Agree Somewhat 3		Strongly Agree 4
1.	There are career development opportunities		1	2	3 4
2.	There is opportunity for staff nurses to participate in policy decisions		1	2	3 4
3.	There are opportunities for advancement		1	2	3 4
4.	Staff nurses are involved in the internal governance of the department		1	2	3 4
5.	There is support for new and innovative ideas about patient care		1	2	3 4
6.	Nursing staff is supported in pursuing further education		1	2	3 4
7.	Staff nurses have the opportunity to serve on hospital and nursing committees		1	2	3 4
8.	Administration listens and responds to employee concerns		1	2	3 4
9.	There is an active in-service/continuing education program for nurses		1	2	3 4
10.	Contributions that nurses make to patient care are publicly acknowledged		1	2	3 4
11.	There is an active quality assurance program		1	2	3 4
12.	There are clinical nurse specialists who provide patient care consultation		1	2	3 4

13 .	There is a chief nursing executive who is equal in power and authority to other top-level hospital executives	1	2	3	4
14.	There is enough staff to get the work done	1	2	3	4
15.	There are enough RNs on staff to provide quality patient care	1	2	3	4
16.	There are adequate support services to allow me to spend time with my patients	1	2	3	4
17.	There is enough time and opportunity to discuss patient care problems with other nurses	1	2	3	4
18.	My salary is satisfactory	1	2	3	4
19.	My nurse manager is a good manager and leader	1	2	3	4
20.	The nurse manager backs up the nursing staff in decision making	1	2	3	4
21.	The nurse manager consults with staff on daily programs and procedures	1	2	3	4
22.	The supervisory staff is supportive of nurses	1	2	3	4
23.	There is praise and recognition for a job well done	1	2	3	4
24.	There is teamwork between doctors & nurses	1	2	3	4
25.	Physicians and nurses have good working relationships	1	2	3	4
26.	There is collaboration between nurses and physicians	1	2	3	4
27.	Physicians provide high quality medical care on my unit	1	2	3	4
28.	There is a preceptor program for newly hired RNs on my unit	1	2	3	4
29.	I work with experienced nurses who know the department	1	2	3	4
30.	I work with nurses who are clinically competent	1	2	3	4
31.	There are standardized policies, procedures, and ways of doing things on my unit	1	2	3	4
32.	There is a good orientation program for newly employed nurses	1	2	3	4

33.	There is floating, so that staff is equalized among units in the hospital	1	2	3	4
34.	Staff nurses actively participate in developing their work schedules/rotations	1	2	3	4
35.	Regular, permanently assigned staff nurses on my unit never have to float	1	2	3	4
36.	Flexible or modified work schedules are available	1	2	3	4
37.	I would recommend this department to a friend seeking employment	1	2	3	4
38.	Given the opportunity, I tell others great things about working on my unit	1	2	3	4
39.	It would take a lot to get me to leave this unit	1	2	3	4
40.	I rarely think about leaving this unit to work somewhere else	1	2	3	4
41.	This medical-surgical unit inspires me to do my best work every day	1	2	3	4
42.	This medical-surgical unit motivates me to contribute more than is normally required to complete my work	1	2	3	4

APPENDIX D

THE MEDICAL-SURGICAL NURSE RETENTION SURVEY:

The McCloskey Mueller Satisfaction Scale

The following questions relate to your work environment. How satisfied are you with the following aspects of your current job? Please circle the number that applies.

	Very Satisfied	Moderately satisfied	Neither satisfied nor dissatisfied	Moderately dissatisfied	Very Dissatisfied
1. control over what goes on in your work setting	1	2	3	4	5
2. opportunities for career advancement	1	2	3	4	5
3. your amount of responsibility	1	2	3	4	5
4. your control over work conditions	1	2	3	4	5
5. your participation in organizational decision making	1	2	3	4	5
6. your autonomy in clinical decision-making	1	2	3	4	5

APPENDIX E

THE MEDICAL-SURGICAL NURSE RETENTION SURVEY:

Negative Acts Questionnaire-Revised

The following behaviors are often seen as examples of negative behavior in the workplace. Over the last six months, how often have you been subjected to the following negative acts at work?
Please circle the number that best corresponds with your experience over the last six months:

1	*2*	*3*	*4*	*5*
Never	*Now and then*	*Monthly*	*Weekly*	*Daily*

1.	Someone withholding information which affects your performance	1	2	3	4	5
2.	Being humiliated or ridiculed in connection with your work	1	2	3	4	5
3.	Being ordered to do work below your level of competence	1	2	3	4	5
4.	Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	1	2	3	4	5
5.	Spreading of gossip and rumors about you	1	2	3	4	5
6.	Being ignored, excluded or banished	1	2	3	4	5
7.	Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life	1	2	3	4	5
8.	Being shouted at or being the target of spontaneous anger (or rage)	1	2	3	4	5
9.	Intimidating behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	1	2	3	4	5
10.	Hints or signals from others that you should quit your job	1	2	3	4	5
11.	Repeated reminders of your errors or mistakes	1	2	3	4	5
12.	Being ignored or facing a hostile reaction when you approach	1	2	3	4	5
13.	Persistent criticism of your work and effort	1	2	3	4	5
14.	Having your opinions and views ignored	1	2	3	4	5
15.	Practical jokes carried out by people you don't get along with	1	2	3	4	5
16.	Being given tasks with unreasonable or impossible targets or deadlines	1	2	3	4	5
17.	Having allegations made against you	1	2	3	4	5

18. Excessive monitoring of your work	1	2	3	4	5
19. Pressure not to claim something which by right you are entitled to (e.g. sick leave, holiday entitlement, travel expenses)	1	2	3	4	5
20. Being the subject of excessive teasing and sarcasm	1	2	3	4	5
21. Being exposed to an unmanageable workload	1	2	3	4	5
22. Threats of violence or physical abuse or actual abuse	1	2	3	4	5

23. Have you been bullied at work? We define bullying as a situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the target of bullying has difficulty in defending him or herself against these actions. We will <u>not</u> refer to a one-off incident as bullying. Using the above definition, please select the most appropriate response from the options below, whether you have been bullied at work over the last six months?

☐ No

☐ Yes, but only rarely

☐ Yes, now and then

☐ Yes several times per week

☐ Yes, almost daily

APPENDIX F

THE MEDICAL-SURGICAL NURSE RETENTION SURVEY:

Authentic Leadership Questionnaire

Instructions: The following survey items refer to your leader's/manager's style, as you perceive it. Judge how frequently each statement fits his or her leadership style using the following scale:

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

My Leader/manager:

1. says exactly what he or she means	0	1	2	3	4
2. admits mistakes when they are made	0	1	2	3	4
3. encourages everyone to speak their mind	0	1	2	3	4
4. tells you the hard truth	0	1	2	3	4
5. displays emotions exactly in line with feelings	0	1	2	3	4
6. demonstrates beliefs that are consistent with actions	0	1	2	3	4
7. makes decisions based on his or her core values	0	1	2	3	4
8. asks you to take positions that support your core values	0	1	2	3	4
9. makes difficult decisions based on high standards of ethical conduct	0	1	2	3	4
10. solicits views that challenge his or her deeply held positions	0	1	2	3	4
11. analyzes relevant data before coming to a decision	0	1	2	3	4
12. listens carefully to different points of view before coming to conclusions	0	1	2	3	4
13. seeks feedback to improve interactions with others	0	1	2	3	4
14. accurately describes how others view his or her capabilities	0	1	2	3	4
15. knows when it is time to reevaluate his or her position on important issues	0	1	2	3	4
16. shows he or she understands how specific actions impact others	0	1	2	3	4

APPENDIX G

THE MEDICAL-SURGICAL NURSE RETENTION SURVEY:

Job Satisfaction Measure

The following question will provide us with insight into your job satisfaction, and intent to leave for medical-surgical nurses in Manitoba.

For the question, please respond based on the following scale:

Not at all satisfied	Somewhat satisfied	Neither satisfied or dissatisfied	Somewhat satisfied	Very satisfied
1	2	3	4	5

1. Overall, how satisfied are you with your job?

Not at all satisfied	Somewhat satisfied	Neither satisfied or dissatisfied	Somewhat satisfied	Very satisfied
1	2	3	4	5

APPENDIX H

THE MEDICAL-SURGICAL NURSE RETENTION SURVEY:

Demographic Questionnaire

Responses to the following questions are a very relevant and key part of this study. Please answer all questions. Remember that all information provided will be kept strictly confidential.

1. What is your highest level of education achieved/completed to date? PLEASE CHECK (✓) ALL THAT APPLY.

   a. RN – diploma……..( )

   b. RN – undergraduate degree (i.e., BN, BScN)…… ( )

   c. RN – undergraduate degree – other (i.e., BA)…….. ( )

   d. RN – graduate degree (i.e., MN; MScN)……( )

   e. other, please specify_____

2. What is your current employment status on the medical-surgical unit? PLEASE CHECK (✓) THE MOST APPROPRIATE RESPONSE.

   a. *staff nurse – part-time……..( )

      *please specify % of EFT currently working_____%

   b. *staff nurse – full-time……( )

      *if you work > full-time on a regular basis, please indicate how many hours of overtime you work/week_____hrs

   c. Clinical resource nurse……..( )

   d. educator…… ( )

   e. CNS/NP…… ( )

   f. other, please specify_____

3. What is your regular shift rotation? PLEASE CHECK (✓) THE MOST APPROPRIATE RESPONSE.

   a. 8 hour day shifts only…… ( )

   b. rotating 8 hours - days/evenings…….( )

   c. rotating 8 hours - days/nights……..( )

   d. rotating 12 hours – days/nights…….. ( )

   e. permanent evenings or nights…….( )

   f. other – please specify_____

4. On average, how many weekends do you <u>have off</u> in a month? PLEASE CHECK (✓) THE MOST APPROPRIATE RESPONSE.

   a. none……..( )

   b. one…….( )

   c. two…….( )

   d. three……..( )

   e. four……( )

5. Please indicate your current primary employer:

   a. Tertiary hospital (i.e., HSC or SBH)…… ( )

   b. Urban community hospital (i.e., Brandon General Hospital, Grace Hospital; Victoria General Hospital; Concordia Hospital, Seven Oaks General Hospital……...( )

   c. Rural, community hospital……( )

   c. Other; please specify_____

6. Please indicate your current primary area of employment:

   a. Medical unit ……( )

   b. Surgical unit…… ( )

   c. Combined Medical/Surgical unit…….. ( )

d. Other; please specify_____

7. Please specify the number of years you have been working as a nurse: _____ years

8. Please specify the number of years you have been working as a nurse

in medical-surgical areas: _____years

9. Please specify the number of years you have been working in your current/same role/position on a medical-surgical unit: _____years

9. Date of birth: _____month _____day _____year

10. SEX (✓): male ☐ female ☐

11. Current marital status. PLEASE CHECK (✓) THE MOST APPROPRIATE RESPONSE.

a. single……( )

b. married/common-law……. ( )

c. widowed……..( )

d. separated/divorced…… ( )

12. What is your annual <u>combined household/family</u> income? PLEASE CHECK (✓) THE MOST APPROPRIATE RESPONSE.

a. $50,000 or less ……( )

b. $50,001 – $75,000……...( )

c. $75,001 - $100,000……..( )

d. $100,001 - $125,000……( )

e. $125,001 - $150,000……( )

f. $150,001 - $175,000……( )

g. $175,001 - $200,000……( )

h. over $200,000…… ( )

APPENDIX I

ENREB CERTIFICATE

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APPROVAL CERTIFICATE

April 21,

TO: [redacted]

FROM:

Re:

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). **This approval is valid for one year only**.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, please mail/e-mail/fax (261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM Project Number: http://umanitoba.ca/research/ors/mrt-faq.html#pr0)**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

APPENDIX J

PROOF OF PERMISSION OF FIGURES

Permission for Figure 1; The Causal Model of Turnover, Price & Mueller, 1981

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Title of article / book Exploring the key predictors of retention in emergency nurses

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